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CHAPTER 2

S/HMO ORGANIZATION AND MANAGEMENT

by

Charlene Harrington, Ph.D.
Associate Professor

Robert J. Newcomer, Ph.D.
Associate Professor

Institute for Health & Aging
University of California, San Francisco 94143

and

Alan Friedlob
Health Care Financing Administration

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CONTENTS

LIST OF FIGURES

LIST OF TABLES

INTRODUCTION

This chapter examines the organizational performance of the S/HMOs over the first 30 months of the demonstration. The intent was to identify factors that seem to contribute to planning and operating a successful S/HMO. Success in this demonstration was defined as providing access for members to appropriate services of high quality, while at the same time controlling utilization and expenditures to ensure the financial viability of the organization.

Although the findings of this study were based on observations of only four S/HMO organizations during the initial start-up period, a number of general conclusions were drawn. The findings indicated the importance of the sponsor having a clear strategic plan, a vision of how the S/HMO model fit with the organization's design for the future and the efficient operation of a risk-based health maintenance organization (HMO). All sites experienced successes and problems in the first 30 months, as can be expected in a demonstration project.

Success in planning and operation was most demonstrable at the Kaiser Permanente Northwest Medicare Plus II demonstration. In contrast, the development of new HMO organizations with acute and ambulatory care services by long term care organization was complex. This suggests that long term care providers interested in pursuing S/HMO development must be willing to make substantial financial and human resource commitments to develop the organizational capacity to provide and manage a full range of health care services for Medicare members.

The provision of enhanced chronic care services as part of the S/HMOs benefit package, on the other hand, presented few organizational and management problems for the four projects. Chapter 6 focuses on case management and chronic care service issues and describes the different models used for the delivery of such services.

The first section of this chapter describes the organization, philosophy, and management of the S/HMO demonstrations. The second section examines the provider arrangements, including access to provider services, the service delivery system, and the financial agreements made with providers.

METHODOLOGY

This chapter covers the first 30 months of project operation from January 1985 through June 1987. Much of the statistical data presented, however, only covers the first 24 months of operational experience because data beyond that period were not yet available at the time this report was written.

Qualitative data were collected through interviews with S/HMO officials at each demonstration. These officials included: S/HMO executive directors and key administrative staff, S/HMO marketing directors, selected S/HMO board

members, and former S/HMO staff. The interviews were conducted in person three times between January and December 1986, and once by telephone in spring 1987. For a listing of those interviewed, see Attachment A. Interviews focused on key organizational factors known to be related to the success of prepaid health plans (Lamb and Associates, 1980; Lewin and Associates, 1986; Slabosky, 1981). Correspondence, contracts, board minutes, reports by the sites, audit reports, and other documents were also collected and analyzed. Particular emphasis was placed on examining how corporate organization, management, and provider arrangements influenced S/HMO performance. A third factor contributing to project success — marketing and enrollments — is addressed in Chapter 4.

BACKGROUND

The S/HMO demonstrations are new organizational entities formed by existing organizations. In establishing the demonstration sites, Brandeis University and HCFA agreed to test the S/HMO model in four different market environments. The models were developed by two types of sponsors:

- Two established HMOs: a successful, established health maintenance organization (HMO) (i.e., Kaiser Northwest) in Portland, Oregon; and a partnership between a mature HMO and an experienced direct long term care service provider (i.e., Group Health, Inc. and Ebenezer Society); in Minneapolis-St. Paul, Minnesota.

- Two types of long term care agencies: Metropolitan Jewish Geriatric Center, Inc., a direct services provider in Brooklyn, New York and SCAN, a long term care service broker in partnership with a large medical center in Long Beach, California.

The S/HMO demonstration tested certain basic organizational and financing features. First, a full range of acute and chronic care services were to be provided through a single organizational structure. Second, the consolidation of services with a coordinated case management system was expected to allow the organizations to improve access to and appropriateness of services delivered. Third, the S/HMOs were to serve a cross-section of the elderly population including the functionally impaired and unimpaired elderly. Fourth, the S/HMOs were financed on a prepaid capitation basis by pooled funds from Medicare, Medicaid, and member premiums. Finally, the S/HMOs were to share the initial financial risks and eventually were expected to assume full financial risk for service costs at the end of the first 30 months of the demonstration.

CORPORATE ORGANIZATION, PHILOSOPHY, AND PLAN MANAGEMENT

In developing each SHMO model, unique organizational structures, philosophies, and management approaches were utilized. This section describes each of the features for the four S/HMOs.

KAISER PERMANENTE MEDICARE PLUS II

The experience of Kaiser Permanente Northwest in establishing its Medicare Plus II S/HMO project is significant because it demonstrates how to plan and operate a successful S/HMO. Kaiser Permanente (KP) Northwest, a nonprofit HMO begun in 1946 has 286,000 members, and operates as part of a national HMO organization located in 12 regions with 5 million members. It is a financially stable organization reporting revenues of $4.5 billion in 1986, with a 9 percent increase in revenues over the previous year. Kaiser's board of 12 nationally prominent members and its chief executive officers and managers have been stable over its years of operation, providing a solid base for a test of an innovative program such as the S/HMO project.

KP Northwest is composed of three separate corporations: Kaiser Foundation Health Plan, Inc. (KFHP); Kaiser Foundation Hospitals (KFH); and Permanente Medical Groups, Inc. (PMG). The director of the Center for Health Research, a part of KFH, initiated, planned, developed, and managed the S/HMO demonstration. Its director serves as the principal investigator and executive director of the S/HMO demonstration and also is a corporate vice president of Kaiser Northwest with over 20 years of HMO experience. The project is housed in the Center, a professionally autonomous, multidisciplinary health services research unit. Established in 1964, it employed 115 persons and had a 1986 budget of about $6 million.

As was the case with its predecessor, KP's Medicare Plus I, (a TEFRA HMO demonstration), the KP's Medicare Plus II S/HMO was conceived as a special research and demonstration project. As a special project, the S/HMO demonstration did not require the approval of the Kaiser Northwest governing board or the larger Kaiser Permanente Medical Care Program corporate board. Approval to move forward with the demonstration came directly from the Kaiser Northwest regional administrator to the Center director. While the larger KP board was aware of the S/HMO, it was not involved in decision making relative to the project.

Consistent with its broad corporate goals, Kaiser's decision to participate in the S/HMO demonstration project was reportedly based on the following objectives:

- To explore ways to control costs for Medicare members through use of long term care substitutes for acute care;
- To examine ways to enhance the plan's Medicare benefit package to maintain a leadership position in a market with emerging competition; and
- To increase flexibility in delivering services to Medicare members.

The willingness to test the S/HMO demonstration was also based on a past history of successful innovative projects sponsored by the Center director including a Medicare HMO demonstration project from 1980 to 1985.

The regional administrator delegated all decision-making authority about the S/HMO demonstration to the Center director. During the planning stages, the project established an advisory committee of 11 members from key community aging and social service agencies. Project staff obtained committee members' advice about marketing and community resources that could be used for referral purposes. This committee met several times over a year and a half and disbanded once the S/HMO became operational.

No major organizational or management problems were identified at the Kaiser project during the first 30 months. The S/HMO project as developed by Kaiser was a small added service to its basic TEFRA program. Only those services unique to the S/HMO were paid for and administered by the demonstration project and all other services were fully integrated into the regular Kaiser program. The Kaiser S/HMO administrative staff included three part-time employees to handle planning, budgeting, reporting, and administration of case management and chronic care services. Other administrative activities were provided by KFHP staff rather than by S/HMO project staff. During the first 30 months, Kaiser had stable leadership within both KP Northwest and Medicare Plus II, and had low personnel turnover rates in project staff (see Table 1). Stable staff and managers along with experienced leaders contributed to Kaiser's management success with the demonstration.

SENIORS PLUS

In contrast to Kaiser, the experience of Group Health, Inc. (GHI), a similarly mature HMO (in partnership with Ebenezer Society, an established long term care provider) illustrates the potential difficulties in developing the S/HMO model when sponsoring organizations were themselves undergoing internal organizational change. Most particularly affected in this instance was a clear direction by the sponsors of Seniors Plus for the organizational innovation they were demonstrating.

The experience of Seniors Plus illustrates a natural tendency for a power imbalance in a S/HMO model built on a partnership of prepaid acute care and long term care providers. Program expenditures heavily weighted toward acute care services tended to increase the influence of the prepaid acute care partner over the long term care organizational partner, except in the area of case management.

The initial impetus for the demonstration came from Ebenezer staff. Ebenezer, as an established institution in Minneapolis for more than 70 years, served over 5,000 elderly, and saw the S/HMO as an opportunity to expand its services. The Ebenezer board of directors, composed of 21 members elected by 47 governing Luthern church congregations, expressed strong interest in the S/HMO concept and met with Brandeis University staff to discuss the project in 1981. These discussions culminated with the board forming an ad hoc committee to study the feasibility of the concept and to consider various options for developing the S/HMO model under Ebenezer sponsorship.

Table 1

STAFF SIZE AND TURNOVER RATES
1985-1986

	Number of Employees Hired Thru 12/85[a]	Total Number of Terminations, Thru 12/85	Staff Size as of 12/85 (in FTE's)[a]	New Employees Hired 1/86 Thru 12/86	Total Number of Terminations, 1/86 - 12/86	Staff Size as of 12/86 (in FTE's)	Turnover Rate (1985)[b]	Turnover Rate (1986)[b]
Elderplan[c]	33	4	29	23	14	38	13.8%	36.8%
Medicare Plus II[d]	NA	1	8	NA	1	11	12.4%	8.8%
SCAN Health Plan	37	9	28	31	16	43	32.1%	37.2%
Seniors Plus	11	1	10	5	4	11	10.0%	36.4%

[a] Staff size was substantially lower at Medicare Plus II and Seniors Plus because both organizations were able to use staff from the sponsoring organization for services such as membership, marketing, computer programming, public relations, and other services.

[b] Turnover rates are calculated by dividing the number of terminations occurring during that year by the staff size at the end of the year.

[c] In addition to the staff at Elderplan, there were 16 employees hired thru December 1985 at GMA. Two terminations occurred at GMA during 1985---leaving a staff size of 14 as of December 1985. Thirty new employees were hired between January and December of 1986. Nineteen terminations occurred during that period, leaving a staff size of 25 as of December 1986. The turnover rates for GMA were 14.3 percent and 76.0 percent during 1985 and 1986, respectively.

[d] Medicare Plus II staff size is expressed as the mean number of full-time equivalents for that year. Employee hires cannot be counted because staff time is allotted to the S/HMO from other Kaiser departments as needed. The termination in 1985 was for a marketing representative. One clerk was terminated in 1986. FTEs are those in administration, case management, marketing, and new member entry.

A key decision made by this ad hoc committee was to select Group Health, Inc. as its acute care S/HMO partner. In reaching this position, the committee reviewed performance reports on all Twin Cities HMOs. Committee members were favorably inclined towards GHI because of its financial position, stable management, member-oriented philosophy, and the fact that GHI did not, at that time, have a Medicare HMO demonstration project.

In fall 1983, the Ebenezer Board approved full implementation of the project and the joint venture with GHI. After the joint agreement was adopted, the decision-making role of the Ebenezer ad hoc committee and board was eliminated, and management decisions were delegated to and made jointly by the chief executive officers (CEOs) of GHI and of Ebenezer.

The partnership agreement called for GHI and Ebenezer to share financial risks and rewards on a 50-50 basis. The partners guaranteed Seniors Plus an initial $600,000 line of credit that was later doubled to $1.3 million. Each party agreed to an exclusive contract for the term of the agreement (i.e., should the agreement terminate, each party was enjoined for an additional three years from entering into another joint venture or other similar arrangement to serve the elderly). This exclusive agreement did not, however, preclude participating in a TEFRA risk contract or Medicaid prepayment demonstration. In 1984, GHI began serving Medicare beneficiaries under a Medicare HMO demonstration and subsequently signed a TEFRA risk contract with HCFA. Initial plans called for beginning the marketing of Seniors Plus prior to initial marketing of the other GHI product for seniors. However, a year-long delay in implementation of the S/HMO in 1984 made this impossible. The uncertainty created by this delay required GHI to pursue an alternate strategy to gain a foothold in the competitive market for senior products in the Minneapolis-St. Paul area.

Although the idea to develop a S/HMO emanated from Ebenezer Society, control of the acute care and ambulatory care delivery system was assumed by its prepaid health plan partner, GHI. Seniors Plus was a distinct corporate entity, but it operated under GHI's State of Minnesota HMO license. In contrast to SCAN Health Plan or Elderplan, Seniors Plus was not a free-standing entity; for all intents and purposes, it was organizationally a GHI product line of business, with a unique long term care component.

Under the terms of the partnership, GHI became responsible for all medical care services and for selected administrative functions (i.e., general administration, membership services including marketing and sales, claims processing, management information services, and limited actuarial functions). Ebenezer functions were clearly oriented to service rather than to management. Ebenezer agreed to provide institutional and community-based long term care services, and to provide the key management staff for Seniors Plus.

The general management of Seniors Plus was under the direction of an executive director who reported to both GHI and Ebenezer CEOs. Seniors Plus was responsible for day-to-day plan management including personnel, policy and procedures development, quality assurance and utilization review, and case

management services including arranging long term care services and service contracts.

GHI assumed a strong influence on S/HMO decision-making while Ebenezer's role was limited to the development of the long term care services. The emergence of GHI influence on the project occurred because GHI recognized a critical need to devise organizational responses to confront its changing market conditions.

A pioneer in the HMO field since 1957, GHI with its 213,000 members once dominated the Twin Cities prepaid health plan market. In more recent years, competition from other HMOs in an increasingly saturated market (i.e., approximately 60% of area population enrolled in prepaid health plans), has made GHI's competitive position more tenuous. In 1986, GHI reported cash reserves of $36 million and an operating budget of $164 million. The amount of excess revenue left after expenses, however, had steadily dropped from $7.7 million in 1984 to $1.6 million in 1986.

Similar to that of GHI, Ebenezer's recent financial performance was cause for management concern. In 1984, the corporation reported losses of nearly $1.4 million. In 1985 and 1986, Seniors Plus contributed to Ebenezer's continuing losses, which were primarily attributable to changes in Medicaid nursing home reimbursement rates and expenses related to senior housing ventures. In February 1987, Ebenezer signed an affiliation agreement with Lutheran General Health Care System of Park Ridge, Illinois, a nonprofit, multi-hospital corporation that reported earnings of $21.9 million on revenues of $237.3 million in 1985. Lutheran General planned to provide funds to Ebenezer for capital improvements and debt repayment.

The general financial problems of both sponsors strongly influenced their decisions with respect to the S/HMO. As Seniors Plus experienced losses during the first 24 months of the demonstration, the sponsors became more concerned about the demonstration. The sponsors had not originally anticipated losses and they became cautious about substantial investments in the project.

GHI's lack of a coherent strategic plan for its Medicare membership initially led to an internal competition between the Seniors Plus S/HMO and the Seniors TEFRA risk contract for scarce organizational resources. Although GHI's CEO philosophically embraced the concept of expanding benefits to Medicare members, he considered the S/HMO costly and difficult to market. Initially, neither the chief financial officer nor the marketing director actively supported the demonstration. It was not until the demonstration had been operating for approximately nine months that GHI recognized the need for a senior-staff liaison between GHI and the Seniors Plus executive director to expedite demonstration decisions. GHI appointed its vice president of marketing, sales, and market services to serve in this capacity. The provision of this liaison reportedly improved the SHMO decision-making process but did not entirely resolve organizational conflicts over the merits of the demonstration.

The issues both partners struggled with included how to avoid adverse selection when marketing the S/HMO in conjunction with the TEFRA contract, how to handle the plan losses related to the low premium, and how to solve marketing problems. These issues were compounded by the fact that GHI was unwilling to make the S/HMO a top priority. The S/HMO was only one of ten GHI product lines and represented the smallest in size, with less than one percent of GHI enrollment at the end of the first 24 months.

One issue for Seniors Plus was the apparent slowness of senior GHI and Ebenezer managers to respond to organizational problems, the chief problem being the marketability of the S/HMO in a highly competitive environment. A contributing factor to this lack of responsiveness was an internal conflict among GHI managers as well as top management turnover unrelated to the S/HMO project. The CEO of GHI left after the first year of the S/HMO project and an acting CEO was appointed for six months until a new CEO was installed.

At Ebenezer, board and CEO disputes unrelated to the S/HMO demonstration led to the CEO's resignation; a new CEO was installed in September 1985. Ebenezer's financial and management problems led to questions about its commitment to the project, principally its continued ability to share losses as stated in the joint partnership agreement. These developments led Ebenezer to reconsider its role in the demonstration and tend to view its participation more narrowly as a service contractor to Seniors Plus.

In the second year, GHI and Ebenezer decided to save money by restricting resources for marketing the S/HMO and placing increased emphasis on containing costs for existing members. This decision was based on a GHI management report that every new Seniors Plus enrollee represented a $10 per member per month loss for GHI while every new Seniors TEFRA risk enrollee represented a $15 per member per month profit. GHI management adopted a minimal growth strategy for Seniors Plus maintaining their commitment to the demonstration, but without giving the S/HMO an emphasized organizational visibility.

The executive director of the S/HMO project served for the first 27 months then resigned to return to Ebenezer, where he had served as a manager prior to development of the S/HMO demonstration project. The associate director of the S/HMO, also a former Ebenezer employee, was appointed to the executive director position after the first director's resignation. The fact that the management of the S/HMO project came from Ebenezer with no HMO experience apparently contributed, at least to some extent, to corporate decision-making problems relative to the project. Internal strains and the uncertainty of the project's future probably contributed to the 36 percent staff turnover rate within the S/HMO during the second year of operation (see Table 1). In addition, during the first 24 months of the demonstration, three different marketing directors were responsible for the S/HMO project. The turnover rates in marketing were related to the marketing problems described in Chapter 4.

In spite of these issues, particularly the problems with marketing the

S/HMO, the Seniors Plus staff appeared to work cooperatively and efficiently. The program had no major problems in establishing provider networks and managing the S/HMO acute, ambulatory, and long term care service delivery system. Day-to-day operations were smooth and nonproblematic.

SCAN HEALTH PLAN

One of the principal organizing forces behind SCAN Health Plan (SHP) and its sponsor, the Senior Care Action Network (SCAN), was St. Mary Medical Center (SMMC) of Long Beach. St. Mary was a 540 bed community hospital, one of 25 acute care facilities composing the 13th largest centrally managed U.S. multi-hospital system, Sisters of Charity Health Care System, Houston, Texas. St. Mary reported revenues of over $138 million in 1986. St. Mary's was seeking to expand its mission to serve older persons in what was also a highly competitive health services market. St. Mary's provided $300,000 in grants and technical and legal assistance to establish SCAN. SCAN was incorporated as a nonprofit California corporation in 1978, with its purpose to plan and coordinate a network of social services for Long Beach seniors. The St. Mary associate administrator served as chairperson of the SCAN board from 1982 to 1984, the planning period of the S/HMO project. SCAN gained experience as a long term care organization during this period, but remained small with about $1.9 million in revenues in 1986.

SHP was incorporated in 1983 as a nonprofit public benefit corporation with SCAN as sole corporate member. As the sole corporate member, SCAN, acting through its board of directors, exercised ultimate control over the health plan including appointment of board members and top management, approval of budgets and contracts, and authority to amend the bylaws and articles of incorporation.

In bidding to be the SHP hospital provider, St. Mary and one other Long Beach hospital agreed to establish a $1 million line of credit to help SCAN finance S/HMO start-up costs. While SCAN discussed this offer with all three bidders, the SCAN CEO and board informally agreed to give St. Mary first consideration. The SCAN CEO and management staff recommended to the SHP board that the demonstration enter into an exclusive arrangement with St. Mary for acute care services. This agreement was approved before SHP began operation and remained in effect during the first 30 months of the project.

During its first 30 months of operation St. Mary Medical Center was the formal contractor for the acute and nursing home services provided by SHP, under a capitated agreement. In addition, prior to the operation of SHP, with encouragement from St. Mary, SHP selected the St. Mary physician group, Physicians of Greater Long Beach (PGLB), as the SHP contractor for medical services. St. Mary operated and managed PGLB and thus had a major influence over PGLB policies and finances. As informal sponsor of SCAN and SHP and as the major provider of SHP acute care, nursing home services, and (indirectly) physician services, St. Mary had a critical interest in decision-making at the S/HMO demonstration.

The St. Mary influence on SHP board decisions shaped the organization, provider delivery system, and financial arrangements of the organization. While both St. Mary and SHP had a strong financial interest in the outcome of the S/HMO, the goals of the organizations may not have been congruent. St. Mary, as an organization with $138 million in revenues in 1986, had an interest in general in maximizing its revenues. To the extent that SHP contracted for services with St. Mary, and its related organizations, SHP was a $4.5 million revenue source for St. Mary in 1986. On the other hand, SHP had a need to control its capitation rate to St. Mary and both had a need to control utilization. SHP's interest in expanding its service providers to increase enrollment was also in conflict with the desire of St. Mary and PGLB to serve as exclusive contractors.

At the same time that the demonstration began to address the problems associated with starting a new organization, SHP experienced instability in governance with an approximately 75 percent turnover of its 12-14 member SHP board between 1985 and 1987. In 1985, 4 members resigned and were replaced by 5 new members. In 1986, 6 members resigned and 7 members were added. Some of the SHP board resignations reportedly were attributable to an inability of board members to resolve conflicts between SHP and its sponsor, St. Mary. Other resignations were the result of normal attrition due to the aging of its board members, and geographical moves of members. Two resignations were necessary in order to avoid conflicts of interest between board members and firms with whom contracts were being negotiated.

The SCAN and SHP boards developed procedures for board operation that required their members to declare any potential conflict of interest and to abstain from making any decisions which might affect them or any institutions with which they are affiliated. Nonetheless, the SHP board was composed of a number of individuals who represented each of the health plans major risk sharing providers. This is done to take advantage of their expertise in health care and to secure their commitment to the demonstration. In addition to the associate administrator of St. Mary, other members of the 1985-1986 board included the president of Physicians of Greater Long Beach; a contract optometrist; a contract dentist; and the CEO of a social service agency with a large SCAN contract and a smaller SHP contract. This strong presence of plan-related providers on the SHP board gave the appearance of potential conflicts and may have disadvantaged consumer members who tended to defer to these parties on financial and contractual matters.

While SHP board members spent a great deal of time on operational matters as evidenced by the frequency of board and committee meetings, they did not appear well-informed about demonstration policy matters. The board did not appear to have had a clear understanding of the demonstration's objectives or to have carefully monitored SHP progress in meeting them. Furthermore, the complexity of issues related to financing, delivery systems, and marketing appeared to be beyond the experience and knowledge of most board members.

During the first 28 months, authority for the management of SHP staff was bifurcated between the plan administrator and the CEO. The SHP administrator

was responsibile for day-to-day management of the medical director, case management services, management information services, marketing, health education services, and general plan administration. The SHP CEO supervised the plan administrator, the public information coordinator, and, most importantly, the financial services director. An annual agreement provided that SCAN deliver these management services to SHP, including those of the CEO and CEO management and support personnel.

The SCAN CEO had no previous experience with HMO management or with the provision of acute and ambulatory care services. The SHP administrator had over 15 years' experience working with HMOs, but no experience in establishing and managing a complex individual practice association (IPA) model. Differences in experience, management styles, and the organizational structure contributed to conflicts over administrative decisions.

In April 1987, the SHP administrator resigned after the board rejected his proposals regarding physician services contracts, changes in his administrative authority and disagreement concerning the appropriate influence of St. Mary Medical Center, and some administrative decisions by the CEO. The CEO assumed all direct management for both SCAN and SHP and the plan administrator was not replaced.

Tensions among top SHP management appeared, in part, to affect staff turnover rates. The SHP turnover rate was 32 percent in 1985 and 37 percent in 1986, higher rates than in the other S/HMOs (see Table 1). In addition, the SHP CEO and administrator terminated several employees, including 3 marketing directors during the first 24 months and 1 in 1987. SHP also terminated two financial managers during this period and one in the start-up period.

Management of a large brokered service delivery system would be difficult under any circumstances. The newness and complexity of acute health care service management in particular was handled through contractual relationships with St. Mary and PGLB. In spite of these contractual agreements, substantial administrative effort and expertise had to be developed at SHP.

ELDERPLAN

The organizational evolution of the S/HMO model at Elderplan, like that at SHP, demonstrated the difficulties of long term care providers entering into acute care services and HMO management. Elderplan was a nonprofit corporation formed by the Metropolitan Jewish Geriatric Center (MJGC) in 1982. MJGC was a large, voluntary nonprofit corporation licensed as a residential health care facility by the New York State Department of Health and wholly committed to providing institutional and community-based long term care services to Brooklyn seniors since 1907. With annual revenues of $55 million, MJGC agreed to cover the start-up costs for Elderplan. MJGC loaned Elderplan up to $1.77 million and guaranteed a low-interest loan of $300,000 from the Robert Wood Johnson Foundation.

The MJGC's stated objective in incorporating Elderplan was to establish an organization capable of operating independently as a health maintenance organization in the State of New York. Governance arrangements acted to ensure Elderplan's control by MJGC since at least two-thirds of the demonstration board of directors were required to be MJGC trustees and three board positions were held by MJGC officers. However, in contrast to SHP board members, MJGC board members tended to be prominent members of the financial community and abided by strict prohibitions against personal board member financial conflict of interest.

The boards of both MJGC and Elderplan were extremely stable. Nine of the 16 members appointed to the Elderplan board in 1982 still served in 1986. In addition, the majority of MJGC board members served on the MJGC board and the Elderplan board during the three years of planning and the 30 months of the demonstration. Stability in board membership added to continuity in decision-making and to a growing expertise among board members in understanding the problems and issues of a S/HMO providing capitated acute care health services. Many Elderplan board members had served on the MJGC board and gained experience with its long term care service delivery and financing system. They were already insightful about issues related to providing chronic care services to functionally impaired S/HMO enrollees.

As Elderplan became operational and began to experience marketing difficulties and other start-up problems, board members, at the urging of the Elderplan Executive Director and General Director, assumed a more active advisory role in relation to Elderplan. For example, the board president, at the encouragement of the Executive Director, attempted to cultivate relationships with board members of Maimonides Hospital with the goal of influencing the hospital to extend admitting privileges to Elderplan primary care physicians. While this effort was not successful, the exigencies of Elderplan forced the board to demand a different style of governance for the demonstration than their traditional MJGC governing approach, which was characterized by delegating all operational decision-making to the CEO.

In July 1985, the board's executive committee asked for a marketing plan and authorized additional marketing expenditures. In response to continued enrollment problems, the board established a marketing committee to work with the staff. The board also formed a corporate planning committee that included 3 MJGC officers. The purpose of this committee was to consider options to encourage plan growth and ensure plan survival (e.g., investigate partnerships and other joint ventures with prepaid health plans and insurance companies). The board's consultant recommended that marketing activities could be strengthened by a joint venture relationship with a larger HMO.

In light of Elderplan's experience, governing bodies of long term care organizations contemplating the S/HMO model should first gain familiarity with the financial, delivery system, and marketing issues related to operating a prepaid, acute health care delivery system. Board members interviewed acknowledged that during the planning phase for Elderplan they had not realized how organizationally complex the S/HMO model was or how the

demonstration could adversely affect the sponsor, MJGC. For example, the decision to establish a group model HMO, rather than to rely on an IPA primary care model, was not clearly understood. Even with the active participation of Elderplan board members, management problems persisted throughout the first 30 months of the demonstration.

The CEO of MJGC served as the executive director of Elderplan. Although the CEO had almost 20 years of experience managing MJGC, the CEO had no knowledge of HMO or acute care management. With $55 million in revenues and three major organizations in addition to Elderplan to manage, the CEO of MJGC delegated authority for most decisions to the Elderplan general director during the first 24 months. The CEO was not involved in many of the key planning, organizational, and management decisions relative to Elderplan.

The general director had been the primary initiator and developer of the S/HMO project at Elderplan. The Elderplan general director had ten years prior experience planning and managing a long term care program but no experience managing an HMO. The general director had previously served as the director of planning and community services for MJGC, and fashioned an approach to management after the centralized decision making style of Kaiser's Center for Health Services director.

In fall 1986, the individual who served as the general director since Elderplan's inception became Associate Executive Director of Corporate Affairs for MJGC. The position of general director was assumed by the Elderplan plan administrator, a person with 15 years of experience in health care management including managing an HMO.

During the first 24 months of operation, some internal staff conflicts occurred between the general director and some senior staff, along with low staff morale. Personnel turnover rates at Elderplan increased from 14 percent during the first year to over 36 percent during the second year of operation (see Table 1). The high turnover rates were, in part, symptoms of the stress faced by the staff of a newly formed organization. Other personnel changes were made in the marketing program to respond to marketing problems, where 3 different directors served during the first 24 months. Management problems led to delays in implementing corrective actions when start-up problems occurred. As Elderplan gained experience and some personnel changes were made, the internal conflicts and problems with marketing, management information systems and other program operations began to diminish.

The management of Elderplan was made more difficult by management problems at Geriatric Medicare Associates (GMA) during the first 30 months of operation. The absence of a full-time medical director, coupled with the shortage of physicians, was problematic. In addition, GMA experienced a series of problems with its general administrators, resulting in termination of two administrators. The GMA staff grew from 16 to 46 with a turnover rate of 76 percent between 1985 and 1986, leaving 25 staff members at the end of the period. In early 1986, the Elderplan plan administrator had to assume the GMA administrator position as well as her own. This situation continued until

the fall of 1986, thus diluting the attention the administration could give to Elderplan. After a new administrator was hired at GMA, Elderplan management reported improvements about problems with the receptionist staff and appointment times continued to occur.

PROVIDER ARRANGEMENTS

Critical to the success of any prepaid health plan, including the S/HMO, is the provision of accessible physician care of high quality (Slabosky, 1981; Lamb and Associates, 1980). As Lewin and Associates (1986) have observed, physicians influence an HMO's reputation in the community, and the way physicians are selected, organized, and paid, help define the HMO. Equally important for S/HMO demonstrations are the type of hospital and chronic care provider arrangements. This section discusses how S/HMOs ensured access to provider services and how the service delivery systems and payment methods were designed.

At Medicare Plus II and Seniors Plus, provider service delivery arrangements for the S/HMOs were generally well developed to provide access to S/HMO services. As was expected for financially stable HMOs already serving Medicare beneficiaries through TEFRA risk contracts, Kaiser and Group Health experienced minimal problems in establishing provider service delivery systems, including case-managed chronic care services to selected enrollees. This was not the case at SHP and Elderplan, where deficiencies in provider service delivery arrangements were problematic for acute and ambulatory care services.

KAISER PERMANENTE MEDICARE PLUS II

Access to Services

The basic philosophy of KP service delivery was to fully integrate S/HMO demonstration members into its regular health care delivery system, using its established hospital and physician services. KP had had extensive experience with Medicare enrollees, having had over 20,000 members in cost contracts prior to its 1980 HMO Medicare Plus I demonstration project which enrolled approximately 7,800 Medicare beneficiaries. Its physicians and plan managers generally did not feel the need for geriatric specialists. KP internists had extensive experience with older members.

The medical director for Medicare Plus II was an internist with an interest in geriatrics but no specialized training in geriatrics. During the first year of the S/HMO demonstration, the director allocated 2 half days a month to the S/HMO demonstration for coordination and consultation with S/HMO staff. The S/HMO project also used the services of a geriatrician as a clinical consultant during the first two years of the project, but this physician left KP and was not replaced.

Beginning in 1986, KP urged Medicare members to select their own physician. A survey of 20,000 Medicare members found that many older persons

had not identified a usual source of primary care within the KP system. By encouraging older members to select a regular physician, KP was also attempting to balance physician caseloads and improve access.

One major impact on the KP delivery system of the growth in numbers of elderly enrollees, including S/HMO members, was an increase in the demand for hospital-based social services and home-health care services. In an effort to minimize readmission rates, KP hospital social service departments initiated new discharge planning procedures emphasizing a case management approach to follow hospitalized patients after discharge. S/HMO members who needed chronic care services, however, received case management from the S/HMO staff. Thus, KP made adaptations in both its own delivery system and its S/HMO to ensure access to services for the elderly.

Service Delivery and Payment Methods

Figure 1 shows the Medicare Plus II service delivery and financial arrangements. The Medicare Plus II project as developed by KP was a small service added to the basic TEFRA HMO program. Only chronic care services unique to the S/HMO were paid for and administered by the demonstration project. All other services were fully integrated into the regular KP program. Medicare Plus II had all its basic services provided through KFHP Northwest and its related corportions: Kaiser Foundation Hospitals (KFH) and KP physicians (PMG).

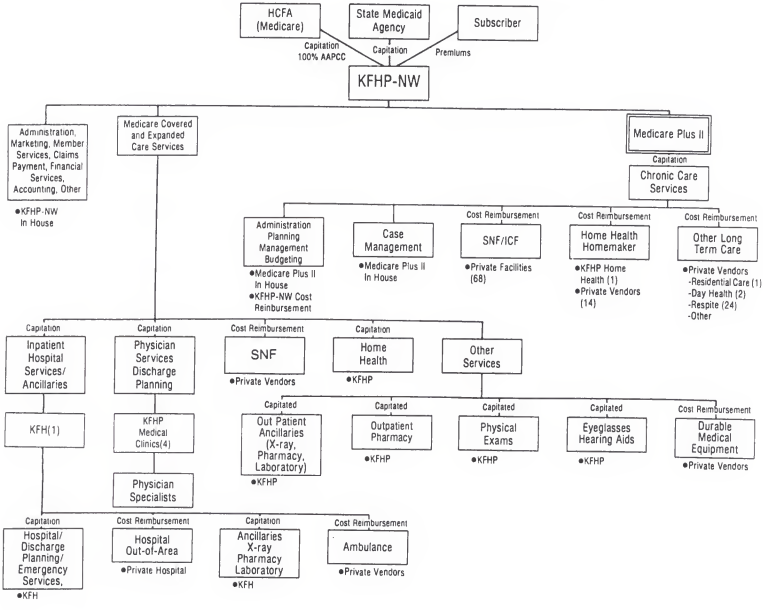
KFH owned and operated two hospitals in Portland, available to S/HMO members. Owning its own hospitals and having its own physician group gave Kaiser strong control over hospital service utilization as well as costs. KFH inpatient hospital services were capitated and included emergency room care, discharge planning, and ancillary services. KFH reported its average acute care hospital rate to be $711 per day. KFHP contracted for additional private hospital services as necessary when the KFHP facilities and emergency room services were full. KP paid 100 percent of the fee-for-service community rates for its extra hospital contract and ambulance services. To give KFH less incentive to refer patients to private hospitals and to control costs, KFH assumed full financial risk for its contract hospital services in 1987.

In 1986, KP operated 10 medical offices used by S/HMO members in the Portland metropolitan area. There were 350 board eligible and certified physicians, representing all the major specialties of medicine and surgery. KP Medicare Plus II developed capitation risk arrangements with its physicians, under an annual negotiated contract. Physicians received incentives for savings made on their own budgets and on hospital utilization. At KP, this incentive has typically amounted to about $2,000-3,000 per physician in years when there was a surplus. During 1986, KFH faced a deficit for the first time in its hospital services (about $800,000), so PMG was not expected to receive an incentive payment in 1986 and was under pressure to reduce utilization and costs.

Physicians were expected to have approximately 26 appointments per day

Figure 1

Kaiser Medicare Plus II Service Delivery System and Method of Payment — 1987



and no additional time was scheduled for Medicare enrollees. Physicians received the same capitation rate for all members; the rate was based on the average for all Kaiser Permanente Medicare and non-Medicare members. While physicians reported concerns about the growing number of Medicare members, they did not appear to have problems with the capitation rate.

KP also provided services beyond basic Medicare coverage such as ancillaries, outpatient pharmacy, physical exams, eye glasses, and hearing aids to Medicare Plus members. These were provided by KFHP under its capitation rate.

Even though KP was an HMO with little experience in providing chronic care services, it had no problems in making arrangements with community agencies for services. KP used its Medicare TEFRA long term care service providers for chronic care, and added a few new providers for those types of services not traditionally provided by Medicare.

KFHP reported using 82 private vendors for Medicare and non-Medicare expanded and chronic care services in 1986. For chronic care services not traditionally covered by Medicare, the S/HMO used 49 separate skilled nursing facilities (SNFs) and 35 intermediate care facilities (ICFs) in the area, although most use was in about 6 SNF/ICF and 4 to 5 ICF facilities. Medicare Plus II also used one residential care facility that had personal care and extended care for respite. KP also used 2 adult day health care agencies in the community for such services, and one of these provided social day care services.

For Medicare and non-Medicare-covered home-care services, KP had its own certified home-health care agency, which also operated its own hospice program and chronic care service program. In 1986, this agency had a budget of $3.4 million, employed 110 full-time staff members (mostly nurses), and made about 52,000 service visits. KP also used 2 certified home-health community agencies for Medicare services, especially when coverage was needed seven days a week and at night. In addition, KP used 12 in-home agencies for homemaker and personal care, 24 for respite and companion care agencies, and other community agencies for chronic care services.

None of KFHP's private long term care vendors had formal contracts, although KP expected to develop formal contracts with long term care vendors in late 1987. It was not until the spring of 1986 that KFHP established a department of community medical services for contracting with community agencies. The initial priority was developing contracts for high-cost, high-technology services such as cardiac surgery. Contracts for long term care services were not planned until later in 1987 or 1988. The primary emphasis on contracts was to control costs and ensure services of high quality.

KP paid all its community vendors on a fee-for-service basis at 100 percent of the community rate. KP's philosophy historically had been to pay community rates in order to ensure access and good relationships with

community providers. In addition, by having its own physicians, KP was able to control its service utilization directly so that paying community rates was not a concern.

SENIORS PLUS

Access to Services

In contrast to the large and stable KP delivery system, the Seniors Plus demonstration began at a time when its sponsor's relations with providers were being transformed. In 1983, Group Health, Inc. (GHI) decided to expand its 30-year-old staff model to establish a network-model HMO, a combination of GHI-staffed clinics and contractual group practices. In 1986, there were 10 affiliated physician contracts representing 23 clinic sites in addition to GHI staff-model clinics. This structural change was designed to improve GHI marketability in the Twin Cities.

GHI physician clinics continued to see approximately 95 percent of all enrollees, while its affiliated clinics served the remaining members. Seniors Plus restricted enrollee physician choice and access to GHI staff physicians at 14 clinic sites (i.e., approximately 200 physicians). Enrollees in the GHI TEFRA risk Seniors plan were free to see any physician affiliated with GHI. While Seniors Plus recognized this structure might limit access somewhat, the decision was made to ensure greater control over plan utilization and expenditures.

GHI management considered establishing a geriatric medicine department and designating a specific hospital for care of its older members but rejected these approaches in favor of integrating Medicare beneficiaries into the usual GHI delivery system, while devising new ways to respond to the special needs of elderly enrollees. GHI reasoned that this approach would: (1) lead to a better quality of care for its geriatric patients; (2) provide better access to services; and (3) help with marketing if patients had more decentralized access to services. Finally, GHI believed that its physicians would be more satisfied if they all had well-rounded practices rather than some having to concentrate on geriatric members.

During the first 17 months of the S/HMO, a GHI geriatrician served both as a regular clinician and part-time medical director for 15-20 percent of his time. After that period, the geriatrician continued as a 10 percent consultant to Seniors Plus and as the medical director for administrative issues. The medical director was involved in utilization review. He particularly worked with the Seniors Plus nurse practitioner, who handled nursing home patients and attended weekly case conferences, and served as a liaison with GHI physicians.

GHI had made some substantial changes in its operation to accomodiate geriatric patients since the implementation of its TEFRA Seniors program and S/HMO Seniors Plus project. The physicians, nurses, and receptionists were trained to be more sensitive to the needs of the elderly, and particularly to

allow same-day appointments with physicians. GHI established a geriatric resource team at each clinic, one or two physicians with a particular interest in geriatric medicine. In 1986, these approximately 30 physicians met regularly in an educational forum to discuss issues related to geriatrics practice. Issues addressed by this system-wide group included the use of prescriptions, nursing homes as substitutes for acute care, and other issues of particular interest to physicians treating geriatric patients. GHI also established a discharge planning team and appointed a geriatric nurse practitioner (GNP) to handle nursing home clients. These activities improved early discharge and coordination of care, particularly care in the transition and rehabilitation facilities GHI used. In addition, in 1982 GHI adopted an encounter-based system for planning physician staffing that allowed Medicare members to be counted on a 1.1 to 1 basis to allow physicians to devote more time to its Medicare members.

Service Delivery and Payment Mechanisms

Revenues for Seniors Plus were sent to GHI, which, in turn, distributed the funds to Seniors Plus on an interim capitation basis, based on per member per month estimated costs. An interim distribution of the revenues was also made to GHI and Ebenezer based on estimated costs. All Seniors Plus, GHI, and Ebenezer payments were ultimately made on a cost reimbursement basis with retroactive adjustments for actual costs, and not on a capitation basis as at KP (see Figure 2).

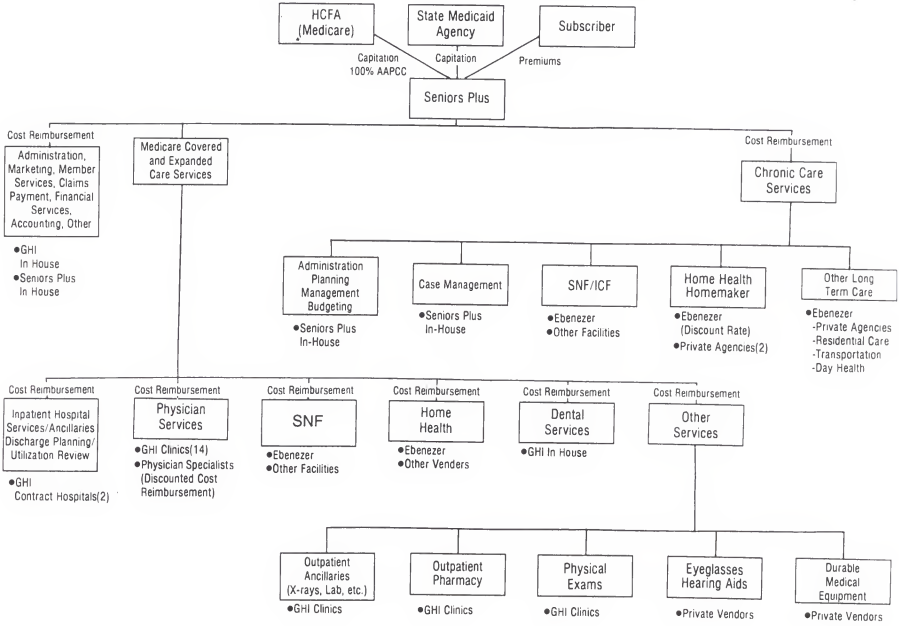
Seniors Plus primarily relied on the GHI and Ebenezer service networks for services (see Figure 2 for service network). GHI traditionally contracted with one hospital in downtown Minneapolis. By 1986, GHI had decentralized its hospital services to use a total of 23 out of the 27 hospitals in the Twin Cities area. Seniors Plus primarily utilized two of these facilities (in downtown Minneapolis and in St. Paul). GHI used standard contracts with each of its hospitals, requiring utilization review, quality assurance, and no discrimination.

In 1985 and 1986, GHI paid all its contract hospitals on a discounted fee-for-service per diem basis (with a volume discount), and had no capitation agreements for hospital services. Seniors Plus reported an average hospital cost of $492 per day in 1985 and $526 in 1986. Since GHI did not have direct financial or utilization control over its contract hospitals, it developed its own system for discharge planning, quality assurance, and utilization review of hospital services. The historic GHI reluctance to contract on a capitated basis was related to the need to gain access to community services. By 1987, access was reportedly no longer a problem and costs became a primary issue. Pressure toward contractual relationships grew so that GHI planned to establish formal risk contracts with selected hospitals in 1987.

Seniors Plus used 200 GHI clinics physicians for medical services. These physicians were salaried and belonged to a loosely organized physician group (but not a bargaining unit). GHI paid 100 percent of costs for physicians services on a salaried basis. GHI physicians received incentives for savings

Figure 2

Seniors Plus Service Delivery System and Method of Payment — 1987



made on their own budget and on hospital utilization. GHI had many of its own specialists on staff, while other specialists were on a contractual arrangement and paid on a cost-reimbursement basis. GHI physicians authorized all specialty referral for Seniors Plus and other GHI patients.

When Medicare risk contracts were initiated, physicians at Kaiser and GHI had reportedly been concerned about the high utilization and costs of the elderly. Both organizations, however, considered the Medicare S/HMO revenues, with age and sex adjustments, adequate. Both Kaiser and GHI had HMO physicians who were experienced, committed to the concept of prepayment, aware of the types of utilization controls necessary, and able to develop sound utilization control mechanisms.

Seniors Plus primarily used Ebenezer programs for Medicare and non-Medicare chronic care services. Although Seniors Plus did not have formal contracts with capitated rates for chronic care services, it appeared to be able to achieve cost savings by utilizing its sponsor for most of its long term care services. No discounts, however, could be obtained on nursing home rates since Minnesota law required all payers of nursing homes to pay the same rates.[1]. The Caroline Center was the primary contractor for Seniors Plus nursing home services. Placement could also occur in any of the 150 licensed SNF/ICF facilities in the area.

The Ebenezer community service program provided other chronic care services to Seniors Plus members, using its own certified home-health care agency that provided 24-hour per day care with health aides as well as homemaker, adult day care, respite aide, transportation, senior companion, caregiver support group, and adult protective services.

Seniors Plus also used the Ebenezer community service program for community services using a fee-schedule for each unit of service. Although Seniors Plus only represented a small proportion of the total volume of the Ebenezer community service program (e.g., about 11% for the home-care services), Seniors Plus received substantially lower rates, along with flexible service arrangements, because of the partnership arrangement.[2] The lower rates reflected the lower amount of supervision and case management service provided by Ebenezer because these services were directly provided by Seniors Plus case managers.

Ebenezer contracted, using a fee schedule for each unit of service, for other Seniors Plus home-health and community-based services with 2 other community vendors when such services were not available through Ebenezer. In this situation, Seniors Plus was able to receive favorable rates because Ebenezer made the subcontract arrangements and received favorable rates due to its large volume of contract services. Close staff relationships and geographic proximity further facilitated effective administrative and financial relationships between Seniors Plus and Ebenezer.

In addition, Seniors Plus contracted directly with other community vendors for such services as lifeline, transportation, and intravenous

therapy. In some cases, homemaker services could also be purchased directly by the family and paid for by the S/HMO.

SCAN HEALTH PLAN (SHP)

Provider relations at SHP and Elderplan were in marked contrast to the established Kaiser and GHI HMO delivery systems. These HMOs could absorb S/HMO enrollees with few dramatic impacts on policies or procedures for providing services or the need to negotiate special financial arrangements with providers. At SHP and Elderplan, new acute and ambulatory care services had to be established to provide basic HMO services. Provider-related problems at SHP and Elderplan were characteristic HMO start-up problems and had little or nothing to do with the implementation of the S/HMO model.

Access to Services

The structure of relationships between SHP and its acute and physician providers created access problems for SHP members and management problems for SHP staff during the first 30 months of the project. Under an exclusive arrangement, St. Mary Medical Center (SMMC) provided all emergency, inpatient, and nursing home care and pharmacy services for SHP. St. Mary hospital had a reputation for services of high quality and was centrally located in the SHP service area. Having only one hospital, however, prevented access to the other two hospitals in the community that also had good reputations. The decision to use only one hospital, although recognizing these benefits from multiple hospital affiliations, reflected a practical trade-off. Without an exclusive hospital contract the much needed $1 million unsecured, subordinated loan would not have been possible in helping to start-up the demonstration.

SHP physician services were provided by a contract with Physicians of Greater Long Beach (PGLB), an independent practice association organized by St. Mary in 1984. As a new organization, PGLB had no experience with prepaid health care delivery. Interviews indicate that PGLB was formed as a defensive response to physician competition. PGLB physicians saw the IPA as a way of retaining their patients. A loosely knit group of independent practitioners, PGLB spent a relatively small amount of time in educating physicians on issues of planning and operating an IPA. Initially, PGLB had 22 primary care physicians and approximately 130 specialists. Even though some SHP members reported that they liked the choice of physicians offered by the SHP (IPA) model (see Chapter 5), the total number of SHP primary care physicians and their geographical distribution were relatively limited. Not until spring 1987 did PGLB increase physician access for its SHP members by adding 8 additional primary care physicians, including 4 satellite clinics.

Difficulties in fashioning strong, positive relations between SHP and PGLB were compounded by a lack of effective IPA management. Initially, SHP hired a quarter-time medical director, who also served quarter-time as the PGLB medical director and was a member of PGLB in private practice. At the end of the first year, this physician was replaced by an acting medical director, a PGLB physician who devoted less than one-quarter time to SHP for

the next 9 months. Neither director had any previous experience with prepaid health care delivery. Approximately 20 months after the S/HMO began operations, PGLB hired a half-time medical director with HMO management experience who also served half-time as SHP medical director. The SHP medical director's primary functions were to direct quality assurance and utilization review activities, particularly to reduce the use of hospitals, nursing homes, and specialist services. The medical director did not have authority to deny utilization, but educated and persuaded PGLB members to control utilization. Although initial relationships between SHP and PGLB were sometimes strained, improvements appeared to occur in 1987, after the new SHP medical director had been hired.

Service Delivery and Payment Methods

Because SHP contracted for all its provider services except for case management, it had little direct control over most of the services provided. SHP control over its providers was limited to the financial arrangements it negotiated in its service contracts. Of the four S/HMO projects, SHP developed the most complex financial arrangements with its physician and hospital providers, incorporating capitation and risk-sharing approaches into its contracts with St. Mary and PGLB. SHP did not have experience providing such services and so was unable to develop rates in the way in which a typical TEFRA HMO would prepare its adjusted community rate (ACR).[3] Nevertheless, the rates were competitive with those paid by the other S/HMOs. (See Figure 3 for a description of the SHP service system and payment methods).

St. Mary Medical Center provided acute care, skilled nursing, and outpatient pharmacy services under a capitation agreement with SHP during the first 30 months. These rates were annually negotiated. The negotiated capitation arrangement was complex, developing incentive pools for SHP, St. Mary, and PGLB for each of the three services separately and for the total of the three as a group. These arrangements were reportedly designed, in consultation with financial experts, by the first SHP plan administrator and the financial consultant, who both left prior to initiation of the demonstration.

The 1985 acute care capitation rate (excluding emergency care) paid to St. Mary was $94.13 per member per month (pmpm), based on a projected hospitalization rate of 2000 days/1000 members at a per diem cost of $595. The purpose of the capitation arrangement was to limit the total amount paid to St. Mary for acute care services. If hospital utilization were held below the capitation level, the hospital would retain the savings.

In addition to this arrangement, SHP withheld funds from the St. Mary rate and contributed additional funds to serve as an incentive pool to be divided between SHP, St. Mary, and PGLB. Table 2 shows the withholdings and contributions to each of the service risk pools and for the incentive distribution arrangements. The incentive pool was designed to give the hospital and the physicians incentives to further reduce utilization and expenditures by allowing them to share in the profits from such controls. SHP

Figure 3
SCAN Health Plan Service Delivery System and Method of Payment for Services — 1987

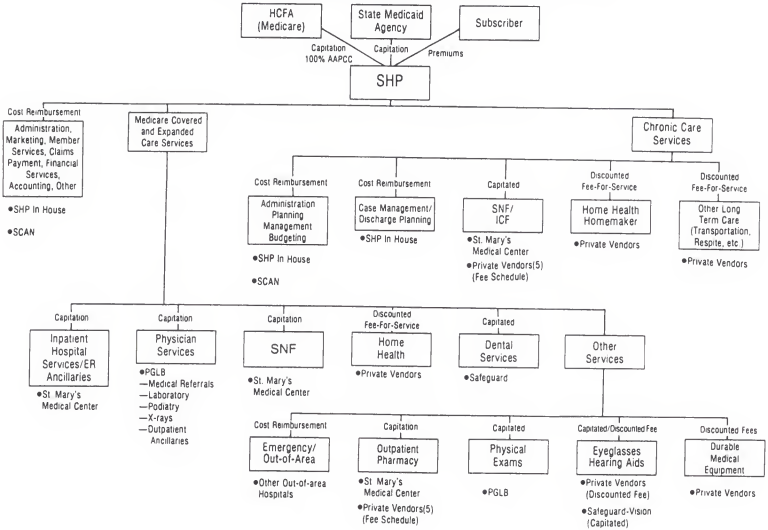


Table 2

1985 RISK-SHARING ARRANGEMENTS FOR SCAN HEALTH PLAN (SHP) WITH ST. MARY MEDICAL CENTER (SMMC) AND PHYSICIANS OF GREATER LONG BEACH (PGLB)

Capitation Withholdings and Contributions to the Incentive Pools

Pool	Per Member Per Month			
	St. Mary Withhold	PGLB Withhold	SHP Contrib.	Total
Inpatient Acute Hospital Services	$4.95	-	$9.90	$14.85
Skilled Nursing and Long Term Care	1.59	-	3.18	4.77
Outpatient Pharmacy	.58	-	1.16	1.74
Physician	-	8.00	-	8.00
Total	7.12	8.00	14.24	29.36

Inpatient Acute Hospital Services Incentive Pool[a]

Days per 1,000 Enrollees	Incentive Pool Distribution		
	St. Mary	PGLB	SHP
1,700	$ -	$142,200	$ 36,000
1,800	18,000	124,200	36,000
1,900	45,000	115,200	18,000
2,000	59,448	100,752	18,000
2,100	118,896	41,304	18,000
2,200	173,200	5,000	-
2,200	178,200	-	-

Skilled Nursing and Long Term Care Incentive Pool[b]

Cost per 1,000 Enrollees	Incentive Pool Distribution		
	St. Mary	PGLB	SHP
305,280	$ -	$ 45,792	$ 11,448
305,280	-	45,792	11,448
324,360	-	42,930	14,310
343,440	5,724	40,068	11,448
362,520	14,310	37,206	5,724
381,600	19,080	32,436	5,724
400,680	38,160	13,356	5,724
419,760	57,240	-	-

Table 2 (Continued)

Outpatient Pharmacy Incentive Pool[c]

Cost per 1,000 Enrollees	Incentive Pool Distribution		
	St. Mary	PGLB	SHP
110,880	$ -	$ 16,920	$ 3,960
117,810	-	15,930	4,950
124,740	1,980	14,940	3,960
131,670	4,950	13,950	1,980
138,600	6,930	11,970	1,980
145,530	13,860	5,040	1,980
152,460	20,880	-	-

Physician Incentive Pool

Inpatient Acute Hospital Days per 1,000 Enrollees	Incentive Pool Distribution	
	St. Mary	PGLB
2,000 or less	$ -	$76,800
2,100	15,360	61,440
2,200	30,720	46,080
2,300	46,080	30,720
2,400	61,440	15,360
2,500	76,800	-

Physician Incentive Pool for Outpatient Pharmacy

Prescriptions per 1,000 Enrollees	Incentive Pool Distribution	
	St. Mary	PGLB
12,000 or less	$ -	$19,200
12,600	3,840	15,360
13,200	7,680	11,520
13,800	11,520	7,680
14,400	15,360	3,840
15,000	19,200	-

Source: SCAN Health Plan and St. Mary Medical Center Provider Agreement for 1985.

[a] Each day of care at another hospital resulting from an emergency shall be charged against the pool as 2 days. Distribution between the breakpoints shall be done proportionately (e.g., at 2,050 days, SMMC would receive 150% of $59,448). Savings below 1,700 days shall be paid by SMMC to SHP at the rate of $297.24 per day. Such amount shall be placed in a Risk Stabilization Pool. The balance of savings shall be retained by SMMC. The Risk Stabilization Pool shall be used to defray any overall net losses.

Table 2 (Continued)

[b] Costs shall be determined as follows for care rendered at SMMC:

Skilled Nursing	$112.00 per day
Chronic Care	52.00 per day
Ancillaries	75% of billed charges not to exceed an average of $98 per day during contract year

For care rendered by others, the actual payments were not to exceed $210.00 per day on the average during contract year. Distribution of risk pools between breakpoints shall be done proportionately. Savings below $305,280 will be retained by SMMC to the extent necessary to defray any net loss in the combined acute and pharmacy incentive pools and the balance of savings shall be paid by SMMC, one-half to SHP and one-half to Risk Stabilization Pool. One-half the savings between $324,360 and $305,280 to be kept by SMMC, one-half to be paid by SMMC to the Risk Stabilization Pool.

[c] Costs shall be charged against incentive pool as follows: pharmaceuticals supplied by SMMC outpatient pharmacy will be at billed charges and those supplied by other pharmacies will be actual payments. Distribution between breakpoints shall be done proportionately. Savings below $111,880 will be retained by SMMC to the extent necessary to defray any net loss in the combined acute and long term care incentive pools and the balance of savings shall be paid by SMMC, one-half to SHP and one-half to Risk Stabilization Pool. One-half the saving between $117,810 and $110,880 to be kept by SMMC, one-half to be paid by SMMC to the Risk Stabilization Pool.

expenditures by allowing them to share in the profits from such controls. SHP arrangements gave the physicians a greater share of the incentive pools when hospital utilization was low and reduced their share when utilization was high. The hospital received a greater share of the incentive pool when utilization was high to offset the higher costs they would incur. When hospital utilization was highest, the incentives would go to the hospital and not to SHP or the physicians. Thus, the incentive pool distribution arrangements provided some protection to the hospital for higher than expected utilization.

The actual 1985 inpatient care utilization experience was 1,858 per 1,000; therefore, St. Mary saved approximately $62,100 on the difference between capitation and projected costs, plus $26,000 from the incentive risk pool. Table 3 shows the distribution of the acute care incentive pool funds. While St. Mary retained the difference in payments, the acute care savings were small in comparison to potential risk. Moreover, St. Mary claimed that its initial per diem rate was substantially lower than its actual per day costs. According to their estimates, the hospital would have received $595,330 in additional dollars if it had been paid under the Medicare prospective diagnosis-related group payment method instead of the capitation method.

The 1986 St. Mary capitation rate for acute care and emergency services increased by 9 percent ($102.71 pmpm including a $12.08 pmpm withholding for the incentive pool) over the previous year.[4] This capitation rate was based on an increase in per day rates of 22% (from $595 in 1985 to $725 in 1986), but based on a lower number of days (1,500 days/1,000 in 1986 compared to 2,000 days/1,000 in 1985). This financial arrangement encouraged the physician and hospital to lower utilization but paid a rate that was more reflective of St. Mary charges than had the initial rate.

The nursing home capitation rate for St. Mary was $30.21 pmpm plus a withholding rate of $1.59 pmpm for 1985 for both Medicare and chronic nursing home as well as for ancillary charges (such as physical therapy, intravenous therapy, and other therapies on the basis of 75% of expected charges). The average capitation rate for nursing home and ancillaries was based on an estimated $210 per day, with incentive factors for utilization below an established level (see Table 2).[5] The target utilization rate was 1,400 days per 1,000 members for Medicare nursing home services and 2,100 days per 1,000 members for chronic care nursing home services.

The SHP nursing home per diem rate was higher than St. Mary's Medicare Medicaid SNF rates, and the utilization targets were established at a high level.[5] Because of these financial arrangements, St. Mary received the savings from the incentive pools as well as the savings on the capitation rate during 1985. In spite of the nursing home savings in 1985, the skilled nursing capitation rate for 1986 was increased by 3.8 percent ($33 pmpm with no withholding for the risk pool).

St. Mary also had a capitated contract for pharmacy at a rate of $10.97

Table 3

SCAN HEALTH PLAN
1985 CAPITATION RATES AND DISTRIBUTION OF INCENTIVES

St. Mary Capitation Rates and Year-End Balance

Service	Capitation Rates	Payment	Costs	Balance
Acute	$94.13 pmpm	$871,644	$1,402,369	$-515,310
LTC/SNF	$30.21 pmpm	$279,745	$195,577	$84,167
Pharmacy	$10.97 pmpm	$101,582	$217,820	$-116,238

Incentive Pool	Total Pool	Distribution		
		St. Mary	PGLB	SHP
Acute	$137,511	$25,974	$ 91,812	$19,723
LTC/SNF	44,170	-	35,336	8,834
Pharmacy	16,112	16,112	-	-
Total	$197,793	$42,086	$127,149	$28,557
Other Distribution				
Total Savings Between $324,360 - $305,280	$ 14,723	$ 7,361	-	$ 7,361
Total Savings Below $305,280	40,003	40,003	-	-
Total	$ 54,726	$47,364	$ -	$ 7,361

SOURCE: St. Mary Medical Center Statistics reported on May 27, 1986, for the period of March 1, 1985 through February 28, 1986.

for 1985, based on an estimated rate of 1 prescription pmpm. Table 2 also shows the pharmacy incentive risk pool arrangements. St. Mary had subcontracts with six pharmacies for services on a fee-for-service basis with no utilization controls. Because of this arrangement, St. Mary had a loss of $66,580 in 1985 and actual utilization of 1.68 prescriptions pmpm. Because of its initial pharmacy losses, the 1986 pharmacy capitation rate was increased by 66 percent (to $18.20 pmpm).

The St. Mary agreement with SHP established an overall risk-sharing arrangement that allowed for spreading the risk across two risk pools, nursing home and pharmacy (see Table 2). By dividing the risk pools in 1985, St. Mary received funds from the nursing home savings, and used them to offset its pharmacy losses. See Table 3 for the distribution of the total incentive pool funds in 1985.

In terms of its financial arrangements, SHP was in a relatively weak bargaining position with the hospital. This was in large part because SHP, St. Mary, and PGLB were all without previous experience in delivering HMO services to the elderly, making actual utilization and cost difficult to estimate and control. Moreover, SHP represented only a small proportion of total St. Mary business (3% of its gross revenues in 1986).

The PGLB capitation rate for 1985 was $80 pmpm, with a withholding arrangement for a reserve pool to cover losses and an incentive pool to control physician utilization. PGLB was also at risk for its use of specialty physicians, laboratory, and ancillary ambulatory care services, which were subcontracted on both capitation and fee-for-service agreements.[6] PGLB responsibility for physician services was limited to a maximum of $12,000 for each individual enrollee. PGLB reportedly received about $50,000 in savings on its physician incentive pool in 1985. In addition, PGLB received its share ($127,149 for 1985) of the St. Mary incentive pools for inpatient, nursing home, and pharmacy services to encourage utilization control (see Table 3).

Although some SHP officials considered its 1985 PGLB capitation rate to be too high, PGLB physicians generally considered SHP overall payment rates and incentives to be too low, and its internal distribution to be inequitable. The 1986 capitation rate to the physicians was increased by 6 percent. SHP represented only 5 to 10 percent of PGLB's total physician visits, consequently the SHP had only limited bargaining power with the IPA.

This dissatisfaction reportedly led some physicians to advise their patients not to join SHP and actively lobbied against SHP membership. Other PGLB physicians allegedly refused to accept new SHP members, causing difficulties for new members seeking access to physician services. However, as discussed in Chapter 5, SHP's physicians were generally more successful in helping recruit S/HMO enrollees than were physicians in the other S/HMOs.

Both PGLB internal risk arrangements and hospital utilization incentive pools were complex. PGLB physicians appeared to have difficulty understanding the arrangements. Although efforts were made to educate physicians during the

initial period, and physicians were told that they would receive incentive payments for keeping hospital and physician utilization low, SHP officials and physicians generally reported a poor understanding of the general risk arrangement. Practice patterns reportedly were not influenced toward cost controls to the extent that had been expected under the agreement. Because of problems caused by the complexity of the risk-sharing agreements, refinements in the incentives were implemented in 1987.

In addition to these capitation arrangements, SHP established two other capitated provider contracts for dental and for vision care with a proprietary corporation, Safeguard. The dental contract was for $13.30 pmpm and vision care was for $4 pmpm for a three-year period, with no incentive risk pools. In 1987, SHP reported some problems with these contracts and believed it could obtain better capitation rates with other local providers in the future.

SHP had contracts with many long-term providers for both Medicare and non-Medicare community services. These included agencies for home-health care, home-health aides, homemaker services, transportation, and respite care. These contracts were all on a negotiated discounted fee-for-service basis. SHP had no difficulty in negotiating discount arrangements for its long term care provider contracts because of its volume of services and because SCAN had had relationships with many of the community vendors over the prior nine-year period for its other long term care programs.

In general, SHP was the most innovative of the S/HMOs in establishing capitation rates with financial incentives for provider services. It is not clear, however, whether or not these arrangements achieved the cost savings that SHP had hoped for. Without prior experience, SHP had little information with which to determine its initial rates and had limited cost data on which to base its 1986 and 1987 rates. The rate arrangements appeared to be designed to give greater protection to St. Mary and PGLB than to SHP, in order to encourage their participation and cooperation. In spite of this, both the hospital and physician rates are within a normal industry range for this market area.

ELDERPLAN

Access to Services

The Elderplan selection of physician and hospital providers, like that of SHP, created problems that have negatively affected the project. Having examined and rejected the feasibility of affiliation agreements with the Health Insurance Plan of Greater New York and Maimonides Medical Center, Elderplan initiated contact with the medical director of the Division of Geriatrics and Gerontology, Cornell University Medical College. This led to two Cornell physicians forming Geriatric Medicine Associates (GMA) in the fall of 1982. Elderplan loaned GMA $202,000 for start-up costs and to cover projected operating deficits.

The Cornell physicians and Elderplan envisioned GMA as a group-model HMO

with specialty trained geriatricians that could be supported exclusively by Elderplan enrollees. Elderplan, as founder of GMA, had authority for selection of the GMA medical and management staffs. GMA physicians agreed to provide all medical coverage to Elderplan members, to develop and maintain staff privileges at hospitals and nursing homes affiliated with the plan, and to act as primary care case managers, arranging for specialist consultants as needed.

The exclusivity of GMA's contract with Elderplan, in theory, assured physician commitment to the success of the project. The model allowed for a focus on geriatric medicine and allowed for utilization controls. Unfortunately, this arrangement also fostered a high degree of organizational inflexibility both for the medical group and for Elderplan, in devising ways to creatively respond to complex, unanticipated delivery system issues.

The Elderplan decision to rely on GMA for primary care medical services at only one site resulted in limited geographic access and physician availability for enrollees during the first 24 months of the project. Three physicians were hired in 1985, but one left in three months, so that Elderplan did not have enough physicians during the first 15 months. Six physicians were hired in 1986 and 4 physicians left. Of the 9 physicians hired in the first 24 months, only 4 remained until 1987, which negatively affected continuity of care for Elderplan members. Elderplan reported many complaints related to long waiting times for appointments, dissatisfaction with physician services, and plan disenrollments. By 1987, when GMA had 6 physicians, the number of physician complaints began to decline.

Unlike some members of Physicians of Greater Long Beach, GMA physicians were committed to the S/HMO concept. Unfortunately, these convictions waned when Elderplan grew much more slowly than projected. By the time the Elderplan general director saw the need for a full-time medical director, the original Cornell-based medical director who had been serving half-time was unwilling to assume the position. He had gradually built his private practice and decided to resign from GMA in spring 1986. Not having a full-time medical director and having changed office managers several times led to internal management problems and high turnover rates. These rates, 14 percent in 1985 and 76 percent in 1986, led to further lack of continuity of care and access problems. The problems were also related in part to the uncertainty in Elderplan's enrollment, the heavy workload demands, the difficulties in dealing with a large geriatric practice, and the lack of control over patient admissions at Maimonides.

In January 1987, Elderplan signed a contract with another physician group, Multi-Specialty Medical (MSM). MSM consisted of three physicians and was located in a different sector of the service area. In contrast to GMA, with its related party arrangement with Elderplan, this group was incorporated by one of its physicians and was wholly independent of Elderplan and MJGC decision-making authority.

Elderplan also experienced difficulties with its hospital providers.

Because of its location, its reputation for care of high quality, and its identification with the Jewish community, Maimonides Medical Center was Elderplan's acute care hospital of choice. Because of historical opposition by Maimonides management and physicians to HMOs, especially staff and group-model HMOs, Elderplan was unable to obtain an agreement with Maimonides.

Maimonides denied admitting privileges to GMA physicians during the first 24 months of the demonstration, and granted only consulting privileges. Until January 1987, Elderplan physicians admitted their patients to Maimonides through specialists with admitting privileges. This less-than-satisfactory arrangement diminished the ability of GMA physicians to serve as primary care managers. They had little control over specialist services. Although GMA physicians approved referrals before a specialist could treat an enrollee, they seemed to have little influence over the services provided by the specialist.

Initial limitations on GMA admitting privileges at Maimonides caused Elderplan to seek alternative hospital arrangements. Brooklyn-Caledonian, a 190-bed nonprofit teaching hospital affiliated with Downstate Medical Center filled this role. However, the selection of Brooklyn-Caledonian created a marketing problem for Elderplan. This hospital is located at the edge of the Elderplan service area in what is generally acknowledged as a high-crime neighborhood. The hospital's patient mix (a high proportion of its beds were occupied by low-income Black and Hispanic Medicaid patients) made the hospital less attractive than Maimonides to the primarily white middle-class Jewish and Italian seniors who made up the majority of the Elderplan market.

GMA physicians reportedly found the quality of care at Brooklyn-Caledonian unacceptable. Elderplan members complained when hospitalized there and often demanded hospitalization at Maimonides. During the first 24 months of the demonstration, the majority of hospital admissions were made through specialists at Maimonides.

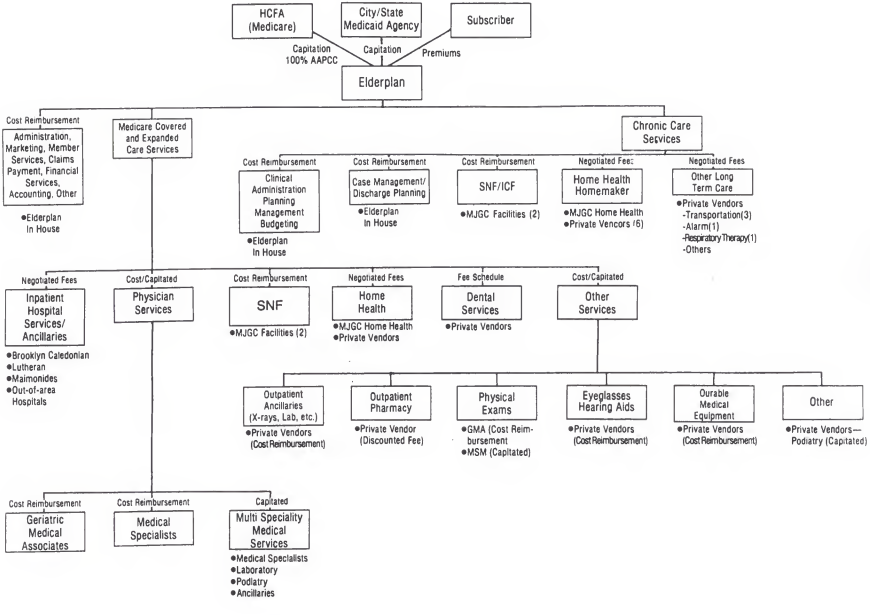
To attempt to correct this problem, Elderplan/GMA entered into a formal arrangement with Lutheran Medical Center in February 1986. However, Elderplan physicians and patients continued to prefer Maimonides. Only a small percent of Elderplan admissions occurred at Lutheran Medical Center during 1986.

Service Delivery and Payment Methods

Figure 4 shows the Elderplan service delivery system and methods of payment to providers. Elderplan paid its hospital providers negotiated prospective fee-for-service rates on a per diem basis. The Elderplan per diem rate at Brooklyn-Caledonian was $424.05 in 1985, and increased to $499.02 in 1986.[7] The Elderplan 1986 per diem rate at Lutheran Hospital was $467.83. The original agreement with Maimonides executed in May 1984 was for a rate of $446.17 per day. By 1986, the Elderplan per diem payment to Maimonides had increased to $504.05. Thus, it cost Elderplan only $5 per day more for its basic rate to admit a patient to Maimonides than to Brooklyn-Caledonian.

Figure 4

Elderplan Service Delivery System and Method of Payment for Services 1987



hospitals would have received under DRGs, plan officials nevertheless considered these payment levels to be too high. Like SHP, Elderplan was in a weak bargaining position because its members represented such a small percentage of total hospital patient days. Further, GMA physicians wanted to use Maimonides hospital regardless of the fact that they did not have admitting privileges. The hospitals all had incentives for long lengths of stay under their per diem payment arrangements. Elderplan had little or no utilization control mechanism either through its physician organization or its own utilization review staff. Thus, Elderplan's provider arrangements contributed to longer lengths of stay and higher hospital expenditures than Elderplan projected.

Initially, Elderplan signed a contract with GMA for a capitation contract. The capitation level and incentive system were developed by Elderplan managers in consultation with an actuary and other consultants. A capitation rate of $90.08 pmpm was set for 1985 with a risk-sharing arrangement and financial incentives to control both hospital and physician use. Under risk-sharing arrangements negotiated with HCFA, Elderplan was at risk for a maximum of $150,000 in losses over the first 18 months of the demonstration and of this risk, Elderplan would assume 60 percent of potential losses (i.e., $90,000) and GMA, 40 percent (i.e., $60,000). To establish the risk pool for GMA, $1.12 pmpm was planned to be withheld from the capitation rate and placed in escrow. If no losses occurred, these funds would be redistributed to GMA at the end of the year. However, before Elderplan began operations, the GMA-Elderplan contract was amended to eliminate GMA's risk-sharing responsibilities until the plan had 4000 members.[8]

Although Elderplan did not require risk sharing of GMA, it established a financial incentive pool for GMA. Elderplan withheld $1.50 pmpm from GMA up to a maximum of $80,000 and equally subdivided these monies into two incentive funds, one for institutional services and the other for medical services. If GMA were able to control hospital and/or physician service use resulting in actual costs equal to or less than 3 percent of budgeted physician and hospital costs, then GMA would receive an incentive of $.33 pmpm up to a maximum of $17,000 if savings were achieved in one risk pool (hospital or physician) and $.66 pmpm up to a maximum of $35,000 if savings occurred in both risk pools (hospital and physician). If the savings were equal to or greater than 5 percent of budgeted costs, GMA would receive higher incentive payments (i.e., $.42 pmpm for savings up to a maximum of $22,500 from one risk pool and $.84 pmpm up to a maximum of $45,000 from both pools).

One major problem for GMA was its relationship with its approximately 120 private physician specialists, which were counted in the GMA incentive pool. In spite of an incentive to reduce specialty referral, GMA had heavy workloads, the need to obtain support from specialists for staff privileges at Maimonides Hospital, and the need to make referrals in order to have patients admitted to Maimonides. For these reasons, GMA reportedly was unable to limit referrals to specialists. Elderplan, further, had to pay 100 percent of the Medicare fee-for-service rates to specialists in order to encourage them to participate. Thus, the specialty physician arrangements were primary

factors in high utilization and costs for both ambulatory care and hospital services at Elderplan during 1985 and 1986.

The target level for total physician expenditures, including all specialists, was $90.08 pmpm for 1985. During 1985, the actual physician costs were over $110 pmpm so no savings occurred on physician utilization and no incentive payments were made to the physicians at GMA.

During 1985, actual hospital expenditures were 15.7 percent less than budgeted (i.e., $85.03 pmpm versus $100.87 pmpm or a $15.84 surplus pmpm). This translated into 15,636 member months times the $.75 pmpm incentive payment for a total payment of $11,727. By this time, the physicians responsible for influencing this reduction in hospital use had left GMA and GMA had experienced overall losses, so Elderplan did not pay out funds from the incentive pool to GMA.

Elderplan reported dissatisfaction with the efficiency of GMA operation, not only because of the management problems reported above, but also because the number of visits per physician was low. Administrators contended that GMA inexperience led to inefficiency and higher costs of operation.

After a long period of seeking other physician arrangements, Elderplan developed a capitation contract with Multi-Specialty Medical (MSM) in January 1987. Its capitation was at $75.95 pmpm to provide all primary and specialty care services, laboratory, podiatry, and ancillary services for a guaranteed number of Elderplan members.[9] A maximum loss of $10,000 per member per year was set. The MSM capitation rate used a 14 percent withhold (i.e., $10.63 pmpm), which was placed in a fund to provide MSM an incentive to control hospital use. Elderplan was in the process of negotiating a similar contract for medical services with other physician groups in 1987.[10] Elderplan expected these changes to have a direct impact on lowering future utilization and expenditures.

Elderplan established three provider service contracts on a capitation basis in late 1986 and 1987, including the MSM physician group, three podiatrists, and a laboratory.[11] In 1985 and 1986, Elderplan's financial arrangements for acute and ambulatory care services were primarily on fee-for-service cost reimbursement basis, but they began to move toward capitation arrangements as a means of sharing risk and attempting to lower utilization.

Elderplan arranged for Medicare and non-Medicare-covered nursing home services (SNF and ICF beds) through formal contracts with the two nursing homes of its parent MJGC. Under the contract, Elderplan paid per diem on the basis of 100 percent of the Medicare cost reimbursement of $130-165 per day in 1985 and 1986. Elderplan paid a fixed rate for an established number of bed days, whether or not the beds were used. Elderplan did not receive a discount on rates by MJGC because its two facilities were facing large deficits, with the adoption of the New York Medicaid nursing home reimbursement system.[12]

Elderplan also had an agreement with MJGC Home Health Agency, a certified and licensed agency for both Medicare and non-Medicare-covered home-health care services and contracts with a number of community long term care vendors. These vendors provided homemaker, housekeeper and personal care services, transportation, durable medical equipment, supplies, and respiratory therapy services for specified fees, and an emergency alarm company provided emergency alarm services.[13] Most of these services were reimbursed at discounted fee-for-service rates. In 1986, Elderplan was able to develop a contract with a discount mail order pharmacy service for its prescription drugs on a discounted cost basis.[14]

In summary, Elderplan had complex arrangements for its service delivery and payment mechanisms. Its service delivery system was primarily a brokered system, like SHP, except for case management services, which were delivered directly. Its financial arrangements were primarily based on cost reimbursement, but after the first 24 months, it was able to establish capitation arrangements with a physician group and two other providers.

DISCUSSION

Two basic S/HMO organizational models were developed: sponsorship by an established HMO (Kaiser Permanente and Group Health, in partnership with Ebenezer, a long term care organization) or by long term care organizations that formed new HMOs (MGJC and SCAN). The primary differences in planning, management, and provider arrangements grew out of these differences in the sponsors.

The two established HMOs (Kaiser Permanente and Group Health with Ebenezer) considered the S/HMO projects to be product lines and integrated them into their existing organizations. Both were experienced in the delivery of hospital and ambulatory care. These HMOs had little experience with the delivery of long term care services, but had no difficulty in establishing organizational relationships and financial arrangements with long term care providers. Group Health arranged for most of its long term care services through its partner, Ebenezer. Kaiser primarily used private vendors in the community for long term care services.

Although there were few problems with the establishment of the delivery systems at the two HMOs, Seniors Plus had its own problems. These included strategic planning and marketing conflicts within Group Health, which had a competing TEFRA HMO that it considered a more viable product than the S/HMO. Although Ebenezer provided the long term care services for Seniors Plus, its influence on the organization and management of Seniors Plus was less that of Group Health, which held the HMO license and provided the acute and ambulatory care services.

The two new HMOs (Elderplan and SHP) needed extensive staff and financial resources to establish prepaid financing systems and acute and ambulatory care delivery systems. These organizations primarily contracted for all acute, ambulatory care, and long term care services, and directly provided only the

administration and case management for the S/HMO projects. Their inexperience in planning acute and ambulatory care services created problems for both organizations, many of which began to be resolved over time. These organizations had no problems in establishing and making financial arrangements for long term care services, which they were already experienced in delivering. Although the problems in building new HMOs from long term care organizations were expected and no different than those of other new HMOs, the difficulties raise questions about the rationale of such an approach for the future.

One ultimate test of organizational success remains whether the four established S/HMOs will continue beyond the demonstration period. Will the two HMOs find the S/HMO projects to be valuable product lines and be willing to continue to offer the S/HMO plan? The two long term care organizations are faced with decisions about the future of the S/HMO organizations they created. Will these organizations want to continue as S/HMOs, and if so, how will they be structured in the future? Will they attempt to become regular HMOs, offering services to a population under age 65 in addition to their Medicare and Medicaid enrollees? Or will they seek waivers from the current HMO regulations to allow them to continue as special organizations without a non-Medicare and non-Medicaid enrollment under age 65? Will they seek partners to help continue their operations or will they want to remain independent organizations?

During the remaining two years of the demonstration, these and many other questions will be addressed by the S/HMOs and their sponsors as they assess their successes, failures, and organizational viability for the future. Meanwhile, the first 30 months of the demonstration have provided invaluable information about the development, organization, and management of S/HMOs.

SUMMARY FINDINGS

- The S/HMO demonstration was planned and implemented using two basic organization types. Two HMOs (Kaiser and Group Health, in partnership with Ebenezer, a long term care organization) entered the demonstration experienced in the delivery, financing, and utilization control of hospital and ambulatory care. They had little experience in the provision of long term care services. Two long term care organizations (Metropolitan Jewish Geriatric Center (MJGC) and Senior Health Action Network (SCAN)), without direct experience as acute and primary care service providers or HMOs, established S/HMOs.

- The two established HMOs (Kaiser and Group Health) treated their S/HMO projects (Medicare Plus II and Seniors Plus) as new product lines within their established health plans. Acute care service delivery was incorporated into the preexisting HMO delivery system, allowing the projects to make efficient use of personnel and administrative resources, and to focus attention on the development of long term care service delivery systems. Kaiser and Group Health with its partner, Ebenezer, had little difficulty negotiating arrangements with long term care

providers. Seniors Plus was able to use the established Ebenezer long term care service network for most of its services, whereas Kaiser made arrangements with private freestanding community vendors for most of its services.

- The two new HMOs (Elderplan and SHP, sponsored by MJGC and SCAN), as long term care organizations, needed extensive staff and other resources to establish an HMO acute and ambulatory care delivery system capacity for their S/HMO projects. Without previous HMO operational experience, these two S/HMOs developed hospital, ambulatory care, and long term care service agreements, primarily through contractual arrangements. Most of Elderplan's long term care services were contracted with its parent corporation, Metropolitan Jewish Geriatric Center (MJGC). SHP contracted all its services with community vendors and itself delivered only case management services.

- Elderplan responded to its inexperience in ambulatory care by initially establishing a group-model HMO in which its physicians contracted with the S/HMO. This decision reduced the choice of physicians and limited access to hospital services when hospital admission privileges at Elderplan's preferred hospital were not approved for its physicians during the first 24 months. A further problem was that the financial arrangements with the physician group provided little incentive for the physicians to control physician and hospital utilization, while other factors encouraged high utilization of specialist referrals.

- SHP elected to enter an informal partnership with St. Mary Medical Center and its physician group. This alliance gave SHP access to acute care expertise and shaped the provider delivery system and financial arrangements for hospital, nursing home, and physician services. These arrangements though practical and rational, at times, conflicted with SHP organizational interests particularly in expanding its market area and in enrollment.

- The presence of St. Mary and other SHP risk contract providers on the SHP board gave the health plan needed expertise in health care delivery, but it may also have affected the health plan's ability to exercise stronger utilization and expenditure controls over hospital, nursing home, and physician services. Tensions relating to these issues appeared to contribute to some internal management disputes and board member turnover.

- The established HMOs were not completely free of management problems. At both sponsoring organizations, Seniors Plus was hampered by the absence of strong consistent GHI and Ebenezer Society support for the S/HMO. This problem was further compounded by turnover in top Group Health and Ebenezer corporate leadership. As a result of the inconsistent management support, S/HMO staff found it difficult to address and resolve S/HMO operational issues related to such basic questions as, for example, how to avoid adverse selection when marketing the product in conjunction

with the Group Health TEFRA risk contract, how to handle initial plan losses related to a price-competitive premium that initially did not cover the costs of the benefits offered, how to develop an effective marketing approach, and how to meet enrollment targets.

- The S/HMOs (except SHP) typically paid for their provider contract services on a fee-for-service basis at standard Medicare and community rates. Elderplan and Seniors Plus did have some success in negotiating discount rates for some services.

- SHP was the only S/HMO that initially developed capitated contractual arrangements for provider services. While these arrangements did not appear to have achieved substantially lower costs during the initial 30 months period, they did enable the health plan to engage its providers in risk sharing.

NOTES

[1] About one-quarter of all nursing home services were handled by Ebenezer's nursing homes and paid the Medicaid nursing home rates based on a Medicaid casemix system with eleven classification levels for four cost centers. Ebenezer used other area nursing homes for the rest of the needed services and paid them the Medicaid rates. The only exception to this was with a rehabilitation center, where GHI had a contract for extended care and post-acute care services through its medical care program. Nursing homes provide basic services but exclude physician and laboratory services from the basic rates. They provide physical and occupational therapy but charge separately for them in most cases. For skilled in-home nursing care, their costs were about $60 per visit but Ebenezer charged only $45 in 1985 and $50 in 1986 for those services to Seniors Plus

[2] Ebenezer was willing to not require 3-4 hour blocks of services for home-health care that were required to other agencies, but provided services on an hourly basis. They charged $27 for adult day health for Seniors Plus compared to $31 for other vendors; $8.50 for homemaking compared to $9.25 for the community rate; and $14.50 for home health aides compared to $15.25 for community vendors. Ebenezer provided 27% of the total SNF/ICF days used by Seniors Plus members (March 1986 HCFA audit). In addition, 55% of the in-home services were rendered by Ebenezer Community Services (March 1986 HCFA audit). There were two large contracts between Ebenezer and home care vendors for the bulk of other in-home services. For the few remaining community service vendors, Seniors Plus paid for services directly on a fee-for-service cost basis without a formal contract.

[3] Federal regulations (42 CFR Part 417.592) specifies that if an HMO's adjusted community rate (ACR) (the equivalent of the premium that the risk organization would have charged Medicare enrollees independently of Medicare payments using the same rates as charged to non-Medicare enrollees) is less than the AAPCC, the HMO would either provide additional benefits or accept a reduced monthly payment from HCFA. The ACR calculation methods are specified by regulation and are subject to review and approval by HCFA.

[4] For 1986, new capitation rates were negotiated among the three partners (SHP, St. Mary and PGLB) and new incentive arrangements were designed. The acute care capitation rate paid to St. Mary was $90.63 based on an estimated $725 per day costs and and estimated utilization of 1,700 days per 1,000. In addition, $12.08 pmpm was withheld from the revenues for the risk incentive pool for acute care use. In addition, $15.00 pmpm was withheld from the PGLB capitation payments to establish the incentive pool for inpatient services. If utilization were below 1900 days, PGLB would receive its entire withhold back, but as utilization increased, PGLB's share would be reduced. SMMC would receive a greater share of the withholds as utilization increased over 1800 days/1000.

[5] The actual capitation rate to St. Mary for Medicare nursing home care was $112 per day and $120 per day times 75% for nursing home ancillaries, for a total of $202 per day for 267 actual days of care in 1985. This was a generous rate considering that St. Mary received approximately $150 per day fee-for-service rates for Medicare patients and $140 per day for Medicaid patients. St. Mary contracted additional Medicare nursing home services with another facility during 1985 which had 217 days of care at $165 per day. This included $23.33 for skilled nursing and $9.67 for long term care services. The skilled nursing cost estimates were based on an expected cost of $200 per day and $65 per day (less 15% for copayments) for long term care and a risk arrangement was established.

The total Medicare nursing home actual utilization for SHP was 52 days per 1000 members at an average cost of $217.73 per day. For SHP members needing chronic care services, St. Mary had contracts to pay community nursing homes approximately $65 per day. The total actual costs for skilled nursing care for SHP members for 1985 was $195,577 compared to the capitation payments of $279,745, showing that St. Mary had a savings of $84,168 on its nursing home pool. Since half of this amount had been placed in the incentive pool, the pool had $44,170 to distribute using its risk-sharing arrangement.

[6] The 1986 PGLB stop loss provisions were as follows: Medical $6.10, surgery, $150; pathology, $1.45; radiology, $13.00; and anesthesiology, $36.00 per unit. The stop loss provision was $12,000 per individual member. The physicians were paid at 10-20% less than the relative value scale (RVS) for each procedure because HCFA prohibited payments above the average Medicare rates.

The PGLB subcontracts included the following: Kiddle Laboratory received a $1.60 pmpm; Coast Radiology at St. Mary received a capitation rate of $4.48; Mulach Eye Center received $5.60 pmpm; the two podiatrists received $0.70 pmpm. New Market Management was given $10 pmpm for administration. Other services, including the plastic surgeons, dermatologists, hospital emergency room physicians, physical therapy, and all other outpatient services in the hospital, were paid on a fee-for-service basis.

[7] Elderplan's contract with Brooklyn-Caledonian Hospital was established on a prospective per diem rate at $424.05 for 1985 including all services of the hospital and the emergency room rate was be $116.02 per visit. The 1986 rates were calculated using the same methodology with an economic trend factor and set at $499.22 per day and its 1987 hospital rate was $516.87. Almost no hospital days were used in 1986 or 1987 at the hospital. Elderplan's contract with Lutheran was signed on January 1, 1986 and provided for a per diem rate of $467.83 for all inpatient acute care services. The emergency room services at Lutheran were paid on the basis of fee-for-service reasonable costs. The original Maimonides Medical Center agreement to provide hospital and emergency services was

written and signed in May 1984 for a rate of $446.17 per diem. The 1986 Maimonides contract increased the rate to $504.05 per day. The emergency room services were also paid on the basis of fee-for-service reasonable costs. Elderplan was negotiating contracts with two additional hospitals in July 1987, including Brookdale Medical Center and Kings Highway Hospital. Kings Highway proposed a substantially lower rate than the other hospitals, which would have increased the savings to Elderplan over the other contracting hospitals.

[8] Before the plan began actual operation, an amendment to the GMA-Elderplan contract was signed on March 5, 1985, removing all the risk-sharing arrangements until the plan has an enrollment of 4,000 members, but continuing the financial incentive arrangements. In the 1985 HCFA audit, the auditors claimed this amended contract was a violation of the original Elderplan protocol approved by HCFA.

The incentive arrangement was that if GMA were to operate at a level at least equal to 3% below the total pmpm capitated rate in a given risk pool, then the GMA would receive an incentive of $.33 pmpm up to a maximum of $17,000 from one risk pool and $.66 pmpm up to a maximum of $35,000 if a savings were made in both risk pools. If the savings were equal to 5% below the total pmpm, then GMA would receive a higher incentive payment of $.42 pmpm for one risk pool up to a maximum of $22,5000 and $.84 pmpm up to a maximum of $45,000 if the savings occurred in both risk pools. The projected hospital expenditures for the period were $100.87 pmpm but the actual expenditures were $85.03 pmpm so that a savings of $15.84 was realized at the end of the first 18 months. (There were 15,636 member months in the period multipled times $.75 gave GMA a final settlement of $11,727.) In June of 1987, Elderplan had not actually given this first-year incentive payment to GMA physicians because the original GMA physicians had left the plan and GMA had lost money overall.

[9] Elderplan estimated that the $75 pmpm capitation for MSM would be equivalent to 88% of the average fee-for-service rate under Medicare. The MSM capitation agreement was based on Elderplan's guaranteeing payment for 250 new members per month for a six-month period (5,250 pmpm) to MSM regardless of the actual number of plan members assigned to MSM during the period. Between 4,500 and 5,250 plan member months, the plan will deduct the difference from the capitation fee payment until the plan pays back the overpayment. If there were more than 5,250 plan member months paid during the initial six-month period, MSM would receive capitation fee payments for the actual number of pmpm. Elderplan reported having been able to meet these membership assignment provisions during the first six months.

The MSM capitation rate was set up with a 14% withhold (or $10.63 pmpm), which was placed in a hospital fund to provide incentives for controlling hospital utilization. The hospital fund was designated as equal to the the total pmpm capitation funds allocated by the plan to hospitals for

actual services provided by the MSM medical group as their primary care provider. If a surplus existed in the withholding fund over the capitation funds allocated on a pmpm basis at the end of the period, MSM would receive 60% of the surplus and Elderplan would receive 40%. If there were a deficit in the hospital fund, 60% of the losses would be paid by MSM from the withholding fund to Elderplan. Any surplus in the fund would be paid to MSM. The inpatient care in nonplan hospital within and out-of-area, skilled nursing, and outpatient surgery in hospitals were excluded from the hospital pool. The hospital payment rate depended on the actual negotiated rate with each hospital.

[10] Elderplan was in the process of negotiating a similar contract for medical services with Lutheran Medical Center Family Physician Health Center in the summer of 1987. While this contract would have slightly higher rates ($79.55 pmpm), the rate included hearing aid and eyeglass benefits and the contract provided for a 20% withholding fund for the hospital incentive pool.

[11] The contract provided for a capitation rate of $1.60 per member per month for all covered foot care services including x-rays. In addition, a 20% withholding fee was subtracted from the rate to be placed in the podiatrist patient care account to be used for podiatry care in a hospital, skilled nursing facility, health-related facility or in instances of in and out-of-area emergency and urgent care. If there was a positive balance in the withholding account, the remaining amount was to be returned to the podiatrist.

[12] The first contract was signed in December 1984 with MJG Nursing Home Company, Inc., a nonprofit corporation organized for skilled nursing and day hospital services, located in Borough Park. The contract provided the following rates for 1985: $165 per day for skilled nursing and subacute care. In addition, the following schedule was established for day hospital care: $115 per 6-hour day, $57 per 3-hour day, and $19 per 1-hour day. The other skilled nursing facility, MJG, Coney Island, offered less intensive care and lower 1985 rates of $130 per day for skilled nursing and $68 per day for the health-related facility services (ICF). Medicare challenged the MJGC rate for last year, so MJGC decided to maintain the 1985 rate in 1986 and 1987 rather than to conduct a rate study. Elderplan also had an agreement with MJGC Home Health Agency, a certified and licensed agency for home-health care services for 1985.

[13] Elderplan had six vendor contracts for homemaker, housekeeper, and personal care services in 1986. The typical rates were about $6.50 per hour for these services. Elderplan had an agreement with a nursing registry to provide supplemental nursing services either in a hospital or at home. The agreement provided for the following rates: $53.23 per visit for nursing services; $13.25 per hour of home health aide; $43 per visit for physical, occupational, or speech therapy. These rates did not change for 1986 or 1987.

Other Elderplan contracts were with 3 medical transportation companies, for about $15 for ambulette services and $8 for car service per ride. Another contract was with an equipment company to provide durable medical equipment, supplies, and respiratory therapy services for specified fees. Elderplan also had a contract with an emergency alarm company to provide emergency alarm response systems on a flat fee schedule for installation and leasing. Elderplan also developed a contract with a discount mail order pharmacy service for all prescription drugs for plan members with a 25% discount on all non-prescription items and based on a fee schedule for drugs.

[14] Elderplan's contract for prescription drugs for plan members was a 25% discount on all non-prescription items and based on a fee schedule for drugs.

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ATTACHMENT A

ELDERPLAN RESPONDENT LIST

HMOs:

Anthony Watson, Executive Vice President and C.E.O.
HIP

Kevin M. O'Neill, Marketing Director
Maxicare

Hap Leabman, Coordinator of Provider Affairs
Blue Cross/Blue Shield
Empire HMO

Dennis Kodner, Executive Director
Elderplan

HOSPITALS:

Barry Yankelowitz, Senior Vice President
David Berger, Assistant Administrator
Maimonides Medical Center

Ann Allen-Ryan, Senior Vice President
Lutheran Medical Center

Dr. Rubin Berlingerblau
Maimonides Hospital

James A. Jordan, Executive Director
The Brooklyn Hospital-Caledonian Hospital

Theresa Franzen, Discharge Planner
Lutheran Medical Center

Fran Calco
Utilization Review
Maimonides Medical Center

Delores Forcenito
Utilization Review
Maimonides Medical Center

Dr. Anthony Caccesse, Chief of Staff
Lutheran Medical Center

Diane Malloy, Chairperson
Bayridge Interagency Council of the Aging
Lutheran Medical Center

Cimillo Messina, Assistant Director
Joan Gigante, Director
Amico Senior Center

LOCAL & POLITICAL:

Joan Leavitt, Aide to Hon. Howard Golden
Burrough President

Commission Janet Sainer
Mary Mayer, Director of Research
New York City Department of Aging

MEDICAL SOCIETIES:

Dr. John DeLuca, President
Bayridge Medical Society

Dr. Paul Finkelstein, President
Kings County Medical Society

Bruce Vladeck, President
United Hospital Fund

INSURANCE:

James Weil, Vice President
Senior Services
Metropolitan Life Insurance Company

BUSINESS AND UNION:

Rosalyn Yasser, Administrator
DC 37 Health & Security Plan

Gerald Samuels, Assistant Director
Health Benefits
Brooklyn Union Gas Company

COMMUNITY ORGANIZATIONS AND SENIOR GROUPS:

Rabbi Shlomo Braun, Director
Social Service Department
Council of Jewish Organizations

Joan Schreiber, Program Director
Senior League of Flatbush

ACADEMIC:

Juanita Wood, Ph.D., Director
Gerontological Education
New School

Jim Knickman, Ph.D.
Professor of Economics
Graduate School of Public Administration

PUBLIC OFFICIALS:

Marc S. Wolfert, Assistant Deputy Administrator
Medical Assistance Program
N.Y.C. Human Resources Administration

Bob Lass
State Medicaid Office

LONG TERM CARE PROVIDERS:

Cathy Poulin
People Care, Inc.

Joan Altomonte, Director of
Patient Services
Certified Home Health Agency
Metropolitan Jewish Geriatric Center

ELDERPLAN ORGANIZATION

Eli S. Feldman, Executive Director
Metropolitan Jewish Geriatric Center

Dennis Kodner, Executive Director
Elderplan

Margaret Nyalka, Plan Administrator
Metropolitan Jewish Geriatic Center

Jeffrey Nichols, Medical Director
Geriatric Medicine Associates, P.C.

Ross Lumpkin, Director
Sales and Marketing
Metropolitan Jewish Geriatric Center

Judith Bruce, Associate Executive Director
Metropolitan Jewish Geriatric Center

Helene Weintraub, Director
Member Services and Education Department
Elderplan

Dr. Kenneth Scileppi
Former GMA Medical Director

Isaac Assael, Chairperson
MJGC Board
M. R. Weiser and Company

Doris Simon, Director
Case Management
Elderplan

Martin Sandhaus, Director
Finance Department
Metropolitan Jewish Geriatric Center

Janet Chartez, Coordinator
Utilization Review
Elderplan

KAISER PERMANENTE MEDICARE PLUS II RESPONDENT LIST

HMOs:

Mary Claire Jorgensen, Manager
Pacificare "Secure Horizons"

Helen Smith, Medicare Director
Mary McWilliams, President
Physician Interhospital Health Plan

Ron Coverdell, Manager
Blue Cross/Blue Shield - First Choice 65+

Thomas Bechtol, President
Physicians Association of Clackamas County (PACC)

Mitch Greenlick, Ph.D., Director
Center for Health Research
Kaiser Foundation Hospital

HOSPITALS:

Jerry Brown, Director of Special Projects
Nancy Connors, Director of Geriatric Services
Pat Beham, Administrative Fellow
Health Link

HEALTH/MARKETING:

Lisa Adatto, Director Medicare Division
Health Choice, Inc.

MEDICAL:

Dr. Don Young, President
Multnomah County Medical Society

BUSINESS AND UNION:

Ed Nieubuurt, Benefits Manager
Techtronics Corporation

Mike Hereford, President
United Food and Commercial Workers, Local 555

Dick Rix, Manager Business Group on Health
Chamber of Commerce

LOCAL ORGANIZATIONS AND SENIOR GROUPS:

Jim McConnell, Director
Aging Services of Multnomah County

Michael Goldwin, Executive Director
Ann Wilkinson, Director of Research
Northwest Oregon Health Systems

James Ferguson
AARP, Chapter 158

POLITICAL:

Drenda Howatt, Staff Assistant
Rich Brown, Staff Assistant
to Congressman Ron Wyden

STATE:

John Hutchinson, Manager
Alternative Delivery Systems Unit
Adult Family Services Division

Sue Dietsche, Manager
Client Care Assistant Unit
Program Assistance Division
Department of Senior Services

Dallas Hardison, Ph.D., Manager
Alternative Delivery Systems
Adult & Family Services Division
Department of Human Resources

Roger N. Olson, MSW, Director
Family Support Services
Metropolitan Family Services

Harvey Young, Nursing Home Administrator
Friendship Health Center

Michael G. Saslow, Supervisor
Senior Services Division
Department of Human Resources

KAISER PERMANENTE ORGANIZATION

Mitch Greenlick, Ph.D., Principal Investigator
Medicare Plus II Expanded Care
Kaiser Center for Health Research

Sara Lamb, Co-Investigator
Medicare Plus II Expanded Care
Kaiser Center for Health Research

Lucy Nonnenkamp, Project Administrator
Medicare Plus II Expanded Care
Kaiser Center for Health Research

Theodore M. Carpenter, Jr.
Vice President & Assoc. Regional manager
Kaiser Permanente

Robert E. Koenen, Associate Administrator
Kaiser Permanente
Kaiser Sunnyside Medical Center

Margaret K. O'Malley, R.N., Director
Kaiser Permanente
Home Health Agency/Hospice

Linda Newman
Claims & Referrals
Kaiser Permanente
Medical Care Program

David Zeps, M.D.
Group Health Inc.
Mt. Scott Medical Group

John Hall, Programmer
Medicare Plus II Expanded Care
Kaiser Center for Health Research

Tom Hussey, Marketing Director
Kaiser Permanente Regional Office

Kay Harris
Membership Services
Kaiser Permanente Regional Office

Ted Colombo
Marketing Department
Kaiser Permanente Regional Office

Lynette R. Doane, Manager
Governmental Reimbursement
Kaiser Permanente Regional Office

Janet Wilkinsen, Continuity of Care Coordinator
Bess Kaiser Medical Center

Ed Kasner, Social Services Director
Bess Kaiser Medical Center

Pam Procopio
Utilization Review
Bess Kaiser Medical Center

Peg Macko
Medicare Plus II
Kaiser Center for Health Research

Kathy Brody
Medicare Plus II
Kaiser Center for Health Research

John Soule
Medicare Plus II
Kaiser Center for Health Research

Barbara Ford
Medicare Plus II
Kaiser Center for Health Research

Susan Conroy
Medicare Plus II
Kaiser Center for Health Research

Beth Gandara
Medicare Plus II
Kaiser Center for Health Research

Jane Wallace
Medicare Plus II
Kaiser Center for Health Research

SCAN HEALTH PLAN RESPONDENT LIST

HMOs:

Sam Ervin, President
SCAN

Hal Johnson, Regional Vice President
Family Health Plan

Nancy Starr, Marketing Director
Secure Horizons
Alan Hoops, Sr. Vice President of Marketing
Pacificare

Louise Pendergrass, Vice President Marketing
Frank Matricardi, Vice President of Planning
Maxicare

Craig Smith, Marketing Director
Tom Gray, Director Public Sales
United Health Plan

HOSPITALS:

Jeff Liebman, Assistant Administrator
Long Beach Memorial Hospital

Jack Weiblen, Chief Executive Officer
Long Beach Memorial Medical Center

Michael Markley, Associate Administrator
St. Mary's Medical Center

COMPETITIVE MEDICAL PLANS OR PPOs:

James Hillman, Administrator
Harriman Jones

Tom McCloy, Acting Medical Director
Physicians of Greater Long Beach

Dr. Richard Rytting, Medical Director
Harriman Jones Medical Clinic

BUSINESS AND UNIONS:

Patricia Miller, Benefits Manager
Esther Wu, Assistant
McDonnell Douglas Corporation
Douglas Aircraft Company

Walt Miller, General Manager
Sharon Schmidt, Office Manager
Long Beach Public Employees Group

George Burton, Assistant to President Bob Gerghoff
United Aerospace Workers

Fred Lodge
Region 6 - LA Council
United Auto Workers

COMMUNITY ORGANIZATIONS AND CONSUMER AGENCIES:

Lucille Baker, I&R Coordinator
Ralph Laudenslayer, Senior Center Director
Long Beach Senior Center

John Hooper
Long Beach Seniors Legislative Council
Long Beach Senior Center

LOCAL REPRESENTATIVES:

Max Shucard, Field Representative
for Assemblyman Dave Elder

Tom Clark, City Councilman

MEDI-GAP AND INSURANCE:

Dan Cross
Blue Cross/Blue Shield
California Insurance Marketing Service

Ed Leibson, Ph.D., Director
Provider Contracting
Blue Cross

SCAN PLAN ORGANIZATION

Pam Robinson
Membership Services Representative
SCAN Health Plan

Fred Brown, Marketing Director
SCAN Health Plan

Ray Lyons, Data Manager
SCAN Health Plan

Peter Cullotta, M.D., Medical Director
SCAN Health Plan

Don Compstock, Former Financial Manager
SCAN Health Plan

Mike Markley, Associate Director
St. Mary Medical Center

Joan G. Wilson
Assistant Administrator of Finance
St. Mary Medical Center

Edward S. Engesser
Director of Finance
St. Mary Medical Center

Angel Ramos, Administrator
Skilled Nursing Unit
St. Mary Medical Center

Bill McMorran, Former Plan Administrator
SCAN Health Plan

Geri Chambers, R.N.
Director of Nursing
St. Mary Medical Center

Rhiannon Acree, R.N., Administrator
Upjohn Health Care Services

Dr. Tom McCloy, President
Physicians of Greater Long Beach
c/o SCAN

Tom Clark, Chairperson
SCAN Health Plan Board of Directors

Bob Nichols, Secretary-Treasurer
SCAN Health Plan Board of Directors

Don Westerland, Chairman of the Board
SCAN
c/o Family Service Agency

Sam Ervin, President and CEO
SCAN Health Plan

Henry Lamb, Administrator
SCAN Health Plan

Sheela Mehta, Director
Case Management & Membership Services
SCAN Health Plan

Marlin Kistner, Controller
SCAN Health Plan

Jane George
Case Management Department
SCAN Health Plan

Elizabeth Brode, R.N.
Utilization Review Unit
St. Mary Medical Center

Joe Kocon, Program Administrator MSSP
SCAN Health Plan

SENIORS PLUS MINNESOTA RESPONDENT LIST

HMOs:

George Haverson, President
Senior Health Plan

Janet Hirsch, Vice President of Marketing
Physicians Health Plan

Jean Bickett, Medicare Coordinator
SHARE

John Laird, Director of Planning, Research & Development
Blue Cross/Blue Shield
HMO Minnesota

Lorraine Johnson, Manager
Individual Marketing
Med. Centers Health Plan

Seniors Plus

HOSPITALS:

James Rice, President
Health Accord, Inc.

Gordon Springer, President
Life Span and Abbott Northwestern Hospitals

INSURANCE:

Don Henyan, Executive Vice President
Northwestern National Life Insurance Company

BUSINESS:

James Kenney, Executive Director
Minneapolis Coalition on Health Costs

James Hetland, Senior Vice President
First Bank of Minneapolis

Laird Miller, Corporate Manager Provider Relations
Honeywell, Inc.

UNION:

Peter Benner, Director
AFSCME Council 6

SENIOR ORGANIZATIONS:

Peter Wycoff, Staff Director
Metropolitan Senior Federation

STATE AND POLITICAL:

Senator Linda Berglin

Judith Hale, Senior Research Analyst
Minnesota Commerce Department

Todd Monson, Program Supervisor
Hennepin County Community Health Department

Robert G. Meyer, Director
Office of New Initiatives
State of Minnesota
Department of Human Services

Glen W. Johnson
Vice President, Development
Abbott Northwestern Hospital

SENIORS PLUS ORGANIZATION

John Selstead, Executive Director
Seniors Plus

Jo Ellen Malone, Associate Director
Seniors Plus

George Halvorson, Chief Executive Officer
Group Health Inc.

Merlyn R. Scroggins, President
Group Health Inc.

Kent Eklund, Chief Executive Office
Ebenezer Society

Dr. Paul Brat, Medical Director
Group Health Inc.

Jack Ebler, Vice President
Sales, Marketing, & Member Services
Group Health Inc.

Brian J. Osberg, Vice President
Medical Contracting and Affiliated Clinical Operations
Group Health Inc.

Ann Carter, Director
Community Services Division
Ebenezer Society

Robert Held, Administrator
Caroline Center
Ebenezer Society

Katie Sparks, Director
East Side Clinics
Group Health Inc.

Betsy Numrich
Member Services
Group Health Inc.

Kathy Cooney, Marketing Director
Group Health Inc.

Pam McGowan
Seniors Plus

Dr. Ken Engberg
Seniors Plus

Kay McKenzie
Group Health Inc.

Kay Jones
Group Health Inc.

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